

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09001

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE TERESA KRESSLEIN				2. Date of Death Month Day Year MARCH 15, 2000		3. Time of Death 1:35 AM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-14-8983		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 31, 1912	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location TOWSON		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 20 DUNVALE ROAD				10f. Zip Code 21204		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HAIRDRESSER		16b. Kind of Business/Industry SALON			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JOHN KRESSLEIN				18. Mother's Name (First, Middle, Maiden Surname) MARY THANNER			
	19a. Informant's Name/Relationship (Type, Print) CHARLES KRESSLEIN/ NEPHEW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 FOSTER AVENUE, BALTIMORE, MARYLAND 21224			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SACRED HEART OF JESUS		20c. Date 3/18/00		20d. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MARYLAND 21224			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) e. ANOXIC ENCEPHALOPATHY Due to (or as a consequence of):							
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. RESPIRATORY ARREST Due to (or as a consequence of):							
	c. FOREIGN BODY AIRWAY OBSTRUCTION Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURES ATRIAL FIBRILLATION						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 03-14-2000		28b. Time of Injury 11:40 A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred Subject choked on food.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Caretaker's Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 20 Dunvale Rd., #304, Towson, Maryland	
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.							
	29b. Signature and title of certifier  Richard L. Linthicum				29c. License number D 31826		29d. Date signed (Month, Day, Year) 3-15-2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. LINTHICUM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204							
	31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09002

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) JOE LANE		2. Date of Death Month Day Year MARCH 13 2000		3. Time of Death 18:22
4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
5. Social Security Number 247-48-4892	6. Sex XX M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08 04 29
9. Birthplace (State or Foreign Country) S.C.				
Usual Residence of Decedent				
10a. State MD	10b. County NA	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 2318 West Lanvale Street		10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Black		Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade College (1-4 or 5+) na		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker		16b. Kind of Business/Industry Local Union No# 194
17. Father's Name (First, Middle, Last) Isom Lane		18. Mother's Name (First, Middle, Maiden Surname) Rectina Burgess		
19a. Informant's Name/Relationship (Type, Print) Michelle Melton-Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2318 West Lanvale Street, Baltimore Md 21216		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State 3-20-00 Baltimore Co, Md
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death) a. ACUTE AND CHRONIC RESPIRATORY FAILURE 3 WEEKS Due to (or as a consequence of):				
b. ASPIRATION PNEUMONIA 2 MONTHS Due to (or as a consequence of):				
c. RENAL INSUFFICIENCY Due to (or as a consequence of):				
d.				
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPOPITUITARISM STATUS POST TRACHEOSTOMY				
23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number P12136		29d. Date signed (Month, Day, Year) MARCH 13 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QING TAN-OLLEY, MD 3001 S. HANOVER ST. BALTIMORE, MD 21225				
31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09003

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Young Legters				2. Date of Death Month Day Year MARCH 18, 2000		3. Time of Death 2:20 AM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-40	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 21 1915		9. Birthplace (State or Foreign Country) PA
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Phoenix		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 13805 Princess Anne Way				10f. Zip Code 21131		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Art Teacher		16b. Kind of Business/Industry Education		
17. Father's Name (First, Middle, Last) Charles Ellis Young				18. Mother's Name (First, Middle, Maiden Surname) Marian Uhl				
19a. Informant's Name/Relationship (Type, Print) Charles F. Legters/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4014 Holly Knoll Dr., Glen Arm, MD 21057				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		20c. Location - City or Town, State Timonium, MD		20d. Date 3/21/00		
21. Signature of Funeral Service Licensee  Lowell M. Lemmon				22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEMORRHAGIC CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D 0039297		29d. Date signed (Month, Day, Year) 3/18/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL K. RO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204								
31. Date filed (Month, Day, Year) MAR 20 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09004

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances M. Litvin				2. Date of Death Month Day Year March 17 2000				3. Time of Death 10:48 PM		
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 154-44-1355		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 21 1916		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent										
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 20 Dunvale Rd. #606				10f. Zip Code 21204		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Charles N. Hochreiter				18. Mother's Name (First, Middle, Maiden Surname) Mary McDermott							
19a. Informant's Name/Relationship (Type, Print) Mrs. Joan Symenski/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Starbit Rd. Towson, Md. 21204							
20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Co.		Date 3-22-00		20c. Location - City or Town, State Towson, MD.					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC UTERINE CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 4 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number D23319		29d. Date signed (Month, Day, Year) MAR 20, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nathan Rosenblum, M.D. 7600 Osler Dr. Towson, Md. 21204											
31. Date filed (Month, Day, Year) MAR 20 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09005

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVIS Francis Lipscomb				2. Date of Death Month MARCH Day 17 Year 2000		3. Time of Death 0721 AM			
	4a. Facility Name (If not institution, give street and number) 8 NORTH ELLAMONT STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A			
Funeral Director	5. Social Security Number 243-14-8274		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 29, 1922			
	9. Birthplace (State or Foreign Country) N. Carolina		10a. State Maryland		10b. County N/A		10c. City, Town or Location BALTIMORE			
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No				10e. Street and Number 8 N. Ellamont Street		10f. Zip Code 21229			
	10g. Citizen of What Country? USA				11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No WW II			
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: black		15. Decedent's Education (Specify only highest grade completed) 8th grade			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAB DRIVER				16b. Kind of Business/Industry Self Employed		17. Father's Name (First, Middle, Last) ROOSEVELT Lipscomb			
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) DELILA T. Lipscomb				19a. Informant's Name/Relationship (Type, Print) MARY COOPER / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 E. LAWRENCE STREET BALTIMORE, Md 21213			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Lutheran Cemetery		20c. Location - City or Town, State Owings Mills, Maryland			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Gerry Haines				22. Name and Address of Facility CHATHAM - HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, Md 21215				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier Theodore M. King				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 18, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed Cause of death (from 23a) (Type, Print) Theodore M. King				31. Date filed (Month, Day, Year) MAR 18 2000				32. Registrar's Signature B. Sparks	
	33. Registrar's Signature B. Sparks				34. Registrar's Signature B. Sparks				35. Registrar's Signature B. Sparks	

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09006

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma Marie McKenna

2. Date of Death

03

Day

14

Year

00

3. Time of Death

1:05 P.M.

4a. Facility Name (If not institution, give street and number)

The Wesley Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-03-6019

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan 16, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
N/A10c. City, Town or Location
Baltimore10d. Inside City Limits
1 ☒ Yes 2 ☐ No

10e. Street and Number

2211 West Rogers Avenue

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Church Secretary

16b. Kind of Business/Industry

Memorial UMC

17. Father's Name (First, Middle, Last)

Lindsey B. McKenna

18. Mother's Name (First, Middle, Maiden Surname)

Mary Frances Riley

19a. Informant's Name/Relationship (Type, Print)

Michael D. Brown (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Holly Road, Severna Park, Maryland 21146

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Balto/Washington Crematory 3/16/00 Laurel, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.

3631 Falls Road, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Severe Dehydration

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Vascular DiseaseHTN in distant past

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

R. Liberty, M.D.

29c. License number

DA1464

29d. Date signed (Month, Day, Year)

3/15/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT LIBERTY, MD 3508 BANK ST BALTO, MD 21224

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

McKenna Thelma
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once

MS2010041 20

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09007

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary O. Mendoza

2. Date of Death

Month Day Year
MARCH 17, 2000 5:29 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

217-20-2175

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jun 27, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2917 Westchester Avenue

10f. Zip Code

21043

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

school teacher

16b. Kind of Business/Industry

New Jersey school system

17. Father's Name (First, Middle, Last)

Edmund John Owens

18. Mother's Name (First, Middle, Maiden Surname)

Mary Magdalene McDonald

19a. Informant's Name/Relationship (Type, Print)

Ms. Melanie Mendoza

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2917 Westchester Avenue Ellicott City, Maryland 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

All County Cremation Services, Inc.

Date

03/21/00

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

END STAGE CHRONIC OBSTRUCTIVE

YEARS

a. Due to (or as a consequence of):

PULMONARY DISEASE

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE RHEUMATOID ARTHRITIS

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D16492

29d. Date signed (Month, Day, Year)

March 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEATRIZ P. DIZON M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

Beatriz P. Dizon

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09008

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul J. Manley

2. Date of Death

Month Day Year
MARCH 16 2000

3. Time of Death

0545

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-42-7085

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 13, 1944

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

DUNDALK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3535 DUNHAVEN RD.

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12thCollege (14 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Millwright

16b. Kind of Business/Industry

BETHLEHEM STEEL.

17. Father's Name (First, Middle, Last)

PAUL B. MANLEY

18. Mother's Name (First, Middle, Maiden Surname)

JULIA KURUCZ

19a. Informant's Name/Relationship (Type, Print)

ROXANN ENDERS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3535 DUNHAVEN RD. BALTO. MD 21222

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH

Date

3/18/2000

20c. Location - City or Town, State

Rosedale, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HARTLEY MILLER Funeral Home CHTD.
7527 HARFORD RD, BALTO. MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEVERE CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

2 MONTHES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

ISCHEMIC CARDIOMYOPATHY

5 YEARS

Due to (or as a consequence of):

CORONARY ARTERY DISEASE.

10 YEARS.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

HOUSE OFFICER

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

MARCH 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANE HONG 110 TOWER JOHNS HOPKINS HOSPITAL.

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09009

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna M. Niemiller				2. Date of Death Month Day Year MARCH 19, 2000				3. Time of Death 1550			
	4a. Facility Name (If not institution, give street and number) ST AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death			
Funeral Director	5. Social Security Number 213-16-9309		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) April 25 1918		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 1219 Carroll Street				10f. Zip Code 21230		10g. Citizen of What Country? United States					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Factory					
	17. Father's Name (First, Middle, Last) James K. Davis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Charlotte E. Moon							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kenneth Davis (Brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 Willmington Avenue Baltimore, MD 21230							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		20c. Date 3/22/00		20d. Location - City or Town, State Elkridge, Maryland					
	21. Signature of Funeral Service Licensee <i>Sharon M. McGehee</i>				22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammond Ferry Road Lansdowne, MD 21227							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Chronic obstructive Pulmonary Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death Days years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Daniel Feinstein, MD House officer</i>				29c. License number P12590		29d. Date signed (Month, Day, Year) March 19, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Feinstein, MD 900 Caton Ave Baltimore, Maryland 21229											
	31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature <i>Beverly B. Sparks</i>									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09010

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Maurice Ness				2. Date of Death Month Day Year March 17, 2000		3. Time of Death 9:35 AM		
	4a. Facility Name (If not institution, give street and number) Ridgeway Manor Nursing Home				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-01-3534	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	8. Date of Birth (Month, Day, Year) 01-15-1904	9. Birthplace (State or Foreign Country) Pennsylvania				
	Usual Residence of Decedent								
10a. State MD		10b. County Baltimore		10c. City, Town or Location Arbutus			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5552 Oakland Road				10f. Zip Code 21227		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Transportation			
17. Father's Name (First, Middle, Last) Maurice Ness				18. Mother's Name (First, Middle, Maiden Surname) Sadie Bare					
19a. Informant's Name/Relationship (Type, Print) Geraldine M. Childress-Tynan				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5552 Dolores Avenue, Arbutus, MD 21227					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 3-20-00		20c. Location - City or Town, State Catonsville, MD			
21. Signature of Funeral Service Licensee <i>Sharon R. [Signature]</i>				22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Rd. Arbutus, MD 21227					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Acute Myocardial Infarction</u> Due to (or as a consequence of): b. <u>Arteriosclerotic Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death few min. several yrs.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Peripheral vascular disease</u> <u>Cognitive dysfunction</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>Geetha Raja</i>				29c. License number D87541		29d. Date signed (Month, Day, Year) March 17, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEETHA RAJA, 4367 Hollins Ferry Rd, Baltimore, MD-21227									
31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature <i>Benita B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2020.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

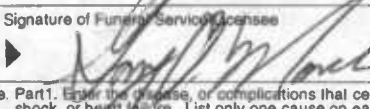
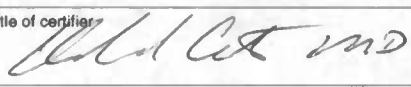
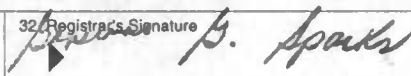
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09011

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Zelma M. Nixon</u>				2. Date of Death Month Day Year <u>MARCH 11, 2000</u>		3. Time of Death <u>12:20 AM</u>		
	4a. Facility Name (If not institution, give street and number) <u>St. Agnes Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>NIA</u>		
Funeral Director	5. Social Security Number <u>214-16-6090</u>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>89</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year <u>Nov. 18, 1910</u>	9. Birthplace (State or Foreign Country) <u>N. Carolina</u>		
	Usual Residence of Decedent								
10a. State <u>MD</u>		10b. County <u>NIA</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <u>2100 Tucker Lane Apt. C2</u>				10f. Zip Code <u>21207</u>		10g. Citizen of What Country? <u>USA</u>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>College (1-4 or 5+)</u> <u>Dyr.</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Telephone Operator</u>			16b. Kind of Business/Industry <u>Hotel</u>		
17. Father's Name (First, Middle, Last) <u>EVANDER MARSHBURN</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Lila Marshburn</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Audrey Bouldin</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2100 Tucker Lane Baltimore, md. 21207</u>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory</u>		20c. Date <u>3-18-00</u>		20d. Location - City or Town, State <u>Catonsville, MD.</u>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>Gary P. March Funeral Home PA 5740 Fredrickton Pass Balto., MD 21289</u>					
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>ACUTE CONGESTIVE HEART FAILURE</u> Due to (or as a consequence of): <u>HYPERTENSION</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 	
29c. License number <u>D0051865</u>				29d. Date signed (Month, Day, Year) <u>MARCH 11, 2000</u>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>CHARLES CURTIS</u>									
31. Date filed (Month, Day, Year) <u>MAR 20 2000</u>		32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09012

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janet M. Oursler

2. Date of Death
Month Day Year
March 15, 2000

3. Time of Death

8:27p.m.

4a. Facility Name (If not institution, give street and number)

5954 Old Washington Rd.

4b. City, Town, or Location of Death

Elkridge

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

213-30-3748

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 11, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5954 Old Washington Rd.

10f. Zip Code

21075

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

18b. Kind of Business/Industry

J. H. Toomey & Sons

17. Father's Name (First, Middle, Last)

John Oliver Merson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ann Hastings

19a. Informant's Name/Relationship (Type, Print)

Gerald Oursler - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5954 Old Washington Rd., Elkridge, Md. 21075

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park

Date

3/20/00

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

Msk. Marshall

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP Inc.
7250 Washington Blvd., Elkridge, Md. 21075

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. metastatic breast cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N/A

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. C

29c. License number

241139

29d. Date signed (Month, Day, Year)

03/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11065 Little Patuxent Pkwy Columbia MD 21044

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09013

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Oehrli				2. Date of Death Month Day Year March 19, 2000		3. Time of Death 8:15 am	
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 343-22-6704		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) March 31, 1928	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) Illinois		10. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Lothian		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 253 Rips Drive		10f. Zip Code 20711		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1946 1967		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) equipment technician		16b. Kind of Business/Industry telephone company			
	17. Father's Name (First, Middle, Last) Oscar Oehrli				18. Mother's Name (First, Middle, Maiden Surname) Ethel Huether			
	19a. Informant's Name/Relationship (Type, Print) Ms. Karen Oehrli				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10316 Whitewasher Way, Columbia, Maryland 21044			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Services, Inc.		20c. Location - City or Town, State Sykesville, Maryland		20d. Date 03/20/2000	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic Ca of rectum Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Approximate Interval Between Onset and Death 8 months							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. N/A						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 041139		29d. Date signed (Month, Day, Year) March 19, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard County General Hospital								
State Registrar	31. Date filed (Month, Day, Year) MAR 20 2000				32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09014

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SALVATORE ORLANDO

2. Date of Death

March 14 2000

3. Time of Death

4:5 AM

4a. Facility Name (If not institution, give street and number)

4766 SHAMROCK AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-10-9151

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

APRIL 16, 1919

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4766 SHAMROCK AVE

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ASSEMBLY LINE

16b. Kind of Business/Industry

CAR ASSEMBLY FACTORY

17. Father's Name (First, Middle, Last)

MARIO ORLANDO

18. Mother's Name (First, Middle, Maiden Surname)

SADIE LO-GUIDICE

19a. Informant's Name/Relationship (Type, Print)

EDWARD HARTMAN (NEPHEW)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

805 WELLINGTON ST. BALTO, MD. 21211

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH

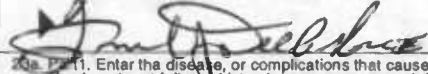
Date

3/17/2000

20c. Location - City or Town, State

BALTO, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

DELLA NOCCE & SONS FUNERAL HOME
322 S. HIGG ST. BALTO, MD. 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY Artery disease
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Euglycemia

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

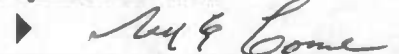
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D20673

29d. Date signed (Month, Day, Year)

3-14-00

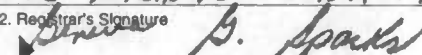
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Lane 7672 Belair Rd BALTIMORE, MD 21236

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.


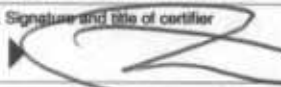

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09015

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nina Irene Claflin Piozet				2. Date of Death Month Day Year March 16 2000		3. Time of Death 2:40 AM		
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare Multi-Medical				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 220-44-8876		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 102 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 8 1897		
	9. Birthplace (State or Foreign Country) Nebraska		10a. State MD		10b. County Baltimore		10c. City, Town or Location Cockeysville		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4 Beechmere Lane		10f. Zip Code 21030		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Education		17. Father's Name (First, Middle, Last) Fremont Manning Claflin		18. Mother's Name (First, Middle, Maiden Surname) Ida Belle Gould	
19a. Informant's Name/Relationship (Type, Print) Dr. Polly Roberts/granddaughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Beechmere Ln., Cockeysville, MD 21030		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Balto. Wash. Crematory		20c. Location - City or Town, State Laurel, MD	
21. Signature of Funeral Director  Michael J. Fagle		22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Silent Arrhythmia Due to (or as a consequence of): Arteriosclerotic Coronary Artery Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death minutes years			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peptic Ulcer Disease Hemolytic Anemia		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D17118		29d. Date signed (Month, Day, Year) Mar 16, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Schwartz M.D. 115 E. Melrose Ave 21212		31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09016

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Parlett				2. Date of Death Month Day Year MARCH 16, 2000		3. Time of Death 8:37 PM		
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 220-22-4463		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) June 14, 1928		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Harford		10c. City, Town or Location Aberdeen		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 743 Cronin Drive		10f. Zip Code 21001		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 Years College (14 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) August Pencek				18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Mekolon					
19a. Informant's Name/Relationship (Type, Print) Mr. Joseph S. Parlett (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 743 Cronin Drive Aberdeen, Maryland 21001					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Date 3/20/2000		20d. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. CLOSTRIDIUM DIFFICILE COLITIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 WEEK			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D24034		29d. Date signed (Month, Day, Year) 3/16/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204		31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature 					

ORIGINAL

Reg. No.

e00 09017

Physician /Medical Examiner

Robert B. Ross

March 18 2000 1:20 PM

4a Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

030-03-9578

6. Sex

1 Male 2 Female

7. Age (In yrs. last birthday)

77

8. Date of Birth (Month, Day, Year)

July 24 1922

9. Birthplace (State or Foreign Country)

Massachusetts

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

2513 Lawnside Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No

14. Race - American Indian, Black, White, etc.

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Public Relations & Consulting

16b. Kind of Business/Industry

Financial

17. Father's Name (First, Middle, Last)

William Ross

18. Mother's Name (First, Middle, Maiden Surname)

Etta Commings

19a. Informant's Name/Relationship (Type, Print)

Phyllis M. Ross/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2513 Lawnside Rd., Timonium, MD 21093

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Michael J. Flagle

22. Name and Address of Facility

Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Chronic Endstage obstructive pulmonary disease

23b. Dtd tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Ramesh Sabapathi, M.D. 821 N. Eutaw St., Suite 308, Balto., MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G 181 3-22-2000 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09018

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marlene M. Roll				2. Date of Death Month Day Year MARCH 14, 2000				3. Time of Death 0845 AM	
	4a. Facility Name (If not institution, give street and number) 607 WEST 33rd STREET				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-90-8443		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 26 Yrs.		8. Date of Birth (Month, Day, Year) Oct 26, 1973		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1400 Weldon Place South				10f. Zip Code 21211		10g. Citizen of What Country? U.S.A			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deli Work				16b. Kind of Business/Industry Eddie's Supermarket	
	17. Father's Name (First, Middle, Last) Robert J. Roll				18. Mother's Name (First, Middle, Maiden Surname) Deborah M. Fincham					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert J. Roll (Father)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 Weldon Place South, Baltimore, Maryland 21211					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State 3/18/00 Baltimore, Maryland					
	21. Signature of Funeral Service Licensee <i>A. Alan Seitz, Jr.</i>				22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE							
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) FOUND: 3-14-2000		28b. Time of Injury FOUND: 8:30		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT INGESTED DRUGS	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN HOUSE		28f. Location (Street and Number or Rural Route Number, City or Town, State) 607 W. 33RD. ST. BALTIMORE, MARYLAND							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>J.M. Titus</i>					29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) MARCH 14, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature <i>B. B. Sparks</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

A77

ORIGINAL

jm
ANTHONY
ROBINSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09019

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Anthony Michael Robinson		2. Date of Death Month Day Year MARCH 15, 2000		3. Time of Death 4:29 P.M.	
4a. Facility Name (If not institution, give street and number) 201 GARDEN RIDGE AVE		4b. City, Town, or Location of Death Catonsville		4c. County of Death BALTIMORE	
5. Social Security Number 216-80-1541	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 33 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 19, 1966
9. Birthplace (State or Foreign Country) MD					
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Ellicott City		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3012 Westchester Avenue		10f. Zip Code 21043		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mechanic		16b. Kind of Business/Industry Automobile	
17. Father's Name (First, Middle, Last) E. Michael Robinson		18. Mother's Name (First, Middle, Maiden Surname) Paulette V. Williams			
19a. Informant's Name/Relationship (Type, Print) Ms. Melissa A. Robinson Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3012 Westchester Avenue Ellicott City, Maryland 21043			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Services, Inc.		20c. Location - City or Town, State Sykesville, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Compression Asphyxia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) GARAGE			
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 3/15/00		28b. Time of Injury UNK M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject pinned under car		28f. Location (Street and Number or Rural Route Number, City or Town, State) 201 Garden Ridge Ave	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.	
29d. Date signed (Month, Day, Year) MARCH 16, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09020

AMEND ITEM: #8 PER F.H. G781 3-20-2000 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Larry Brothwaite Scott				2. Date of Death Month Day Year 3-14-00		3. Time of Death 7:15pm	
	4a. Facility Name (If not institution, give street and number) Joseph Richie Hospice Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 228-74-2253	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7-11-51		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State MD		10b. County		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1925 W. Fayette St.				10f. Zip Code 21223		10g. Citizen of What Country? U.S.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Mamie Scott				
19a. Informant's Name/Relationship (Type, Print) Deborah Harrelson - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134-27 166 Place 5D Jamaica N.Y 11434				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green mount		Date 3/18/00		20c. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Irvin Carroll Funeral Home 1713-14 W. North Ave Balto. MD 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Carcinoma Colon Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4 yrs.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number 008900		29d. Date signed (Month, Day, Year) 3-15-00
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert C. Irwin MD 828 N. Eutan St. Balto Md 21201								
31. Date filed (Month, Day, Year) MAR 20 2000				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State Registrar
DHMH 16 Rev 6/95

7:15pm

3/14/00

LARRY SCOTT

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09021

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph John Schab

2. Date of Death

March 16, 2000

3. Time of Death

8:30 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

213-10-2265

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 11, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

714 South Marlyn Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

St. Of Maryland

17. Father's Name (First, Middle, Last)

John Schab

18. Mother's Name (First, Middle, Maiden Surname)

Honorata Garnicarz

19a. Informant's Name/Relationship (Type, Print)

Marcella Szyjka (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

714 South Marlyn Avenue, Essex, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus

Date

3/20/2000 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdziński Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORNARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

Benjamin B. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Joseph Schab March 16, 2000 8:30 P.M.

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09022

AMEND#8,17&19A PER F.H. G781 3-28-2000 JAB

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Charles Schlingman

2. Date of Death

March 17 2000

Day Year

3. Time of Death

6:00pm

4a. Facility Name (If not institution, give street and number)

Genesis Long Green Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-01-2950

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 11 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2 No

10e. Street and Number

110 West 39th Street Apt 1201

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: USA

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Insurance Agent

16b. Kind of Business/Industry

John Hancock Insurance Company

17. Father's Name (First, Middle, Last)

Henry Schlingman

18. Mother's Name (First, Middle, Maiden Surname)

Clara

19a. Informant's Name/Relationship (Type, Print)

Lilly Schlingman Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 West 39th St #1201 Baltimore, Maryland 21210

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore-Washington

Date

3/20/00

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Michael Carpenter

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. malignant Pericardial Effusion

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

d. Hypertension

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Degenerative Joint Disease

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. J. J.

29c. License number

D31464

29d. Date signed (Month, Day, Year)

3/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOALIZ A. HASHMIL 821 N. Eutaw St Suite 308, Balt. MD 21201

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

11/10/11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09023

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jamie Donald Shoaff

2. Date of Death

MAR 17 2000

3. Time of Death

0754

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital Glen Burnie

4b. City, Town, or Location of Death

4c. County of Death

AA

5. Social Security Number

216-49-9736

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

3

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

FEB. 24, 1997

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6913 GLEN RIDGE CIRCLE APT. B3

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
WHITE15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

DONALD

SHOAFF

18. Mother's Name (First, Middle, Maiden Surname)

CARMEN

YANNUZZI

19a. Informant's Name/Relationship (Type, Print)

CARMEN YANNUZZI SHOAFF-MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6913 GLEN RIDGE CIRCLE, APT B3, GLEN BURNIE, MD 21061

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

3/21/00

20c. Location - City or Town, State

GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, PA.

1 SECOND AVENUE, S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Cardiac Insufficiency

Due to (or as a consequence of):

Minutes

b. Down's Syndrome

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?
☒ Yes ☐ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William P. Jones, MD Deputy

29c. License number

D06054

29d. Date signed (Month, Day, Year)

3/18/00

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

William P. Jones, MD

695 America

21035

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

Jennifer B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09024

Amend Item 23a per Dr., G781, 3/20/00dhb

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louis Tanko				2. Date of Death Month Day Year February 14, 2000		3. Time of Death 4 a.m.																											
	4a. Facility Name (If not institution, give street and number) Cherrywood Nursing Home				4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore																											
Funeral Director	5. Social Security Number 147-20-8590		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 16, 1929																											
	9. Birthplace (State or Foreign Country) New Jersey		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Randallstown																											
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8924 Church Lane		10f. Zip Code 21133		10g. Citizen of What Country? United States																											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 2 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer		16b. Kind of Business/Industry A T & T																													
	17. Father's Name (First, Middle, Last) Louis Joseph Tanko				18. Mother's Name (First, Middle, Maiden Surname) Julia Anna Sedlak																													
	19a. Informant's Name/Relationship (Type, Print) Mrs. Joan Tanko (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8924 Church Lane Randallstown, MD 21133-4784																													
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Crematory		Date Feb. 16, 2000		20c. Location - City or Town, State Laurel, Maryland																											
	21. Signature of Funeral Service Licensee <i>Joseph J. Kellner</i> (M00333)				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133-4784																													
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. Chronic Renal Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death 3 years</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of): Hypertensive Renal Vascular Disease</td> </tr> <tr> <td colspan="6">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Chronic Renal Failure						Approximate Interval Between Onset and Death 3 years	Due to (or as a consequence of): Hypertensive Renal Vascular Disease						b. Due to (or as a consequence of):						c. Due to (or as a consequence of):					
	Immediate Cause (Final disease or condition resulting in death)	a. Chronic Renal Failure						Approximate Interval Between Onset and Death 3 years																										
Due to (or as a consequence of): Hypertensive Renal Vascular Disease																																		
b. Due to (or as a consequence of):																																		
c. Due to (or as a consequence of):																																		
<table border="1"> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">d. Due to (or as a consequence of):</td> </tr> </table>								Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d. Due to (or as a consequence of):																									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d. Due to (or as a consequence of):																																	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier
Ira Hunter Copeland MD
29c. License number
D27034
29d. Date signed (Month, Day, Year)
February 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ira Hunter Copeland MD 5310 Old Court Road Randallstown MD 21133

31. Date filed (Month, Day, Year)
MAR 20 2000
32. Registrar's Signature
Beverly B. Sparks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09025

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPHINE TAYLOR				2. Date of Death Month 3 Day 12 Year 2000		3. Time of Death 3 AM	
	4a. Facility Name (If not institution, give street and number) FUTURE CARE NURSING HOME				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 237-20-8811	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10-2-1915		9. Birthplace (State or Foreign Country) N.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2121 WINDSOR GARDEN APT. 105			10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry DOMESTIC		
	17. Father's Name (First, Middle, Last) JOSEPH PETTAWAY				18. Mother's Name (First, Middle, Maiden Surname) MILLIE PETTAWAY			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) LEON PETTAWAY (SON)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5813 ROYAL OAK AVE. BALTO. MD 21207				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		Date 3-15-2000		20c. Location - City or Town, State WOODLAWN MD	
	21. Signature of Funeral Service Licensee CECIL A ESTEP <i>Cecil A Estep</i>			22. Name and Address of Facility ESTEP BROTHERS FUNERAL SERVICE 1300 EUTAW PLACE BALTIMORE MD 21217				
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DIABETES Due to (or as a consequence of):							
	23b. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. HYPERTENSION ATRIAL FIBILLATION BREAST CA							
Medical Certification: To Be Completed by Physician/Medical Examiner	23c. Immediate Cause (Final disease or condition resulting in death) DIABETES		23d. Due to (or as a consequence of):		23e. Due to (or as a consequence of):		23f. Due to (or as a consequence of):	
	23g. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		23h. Due to (or as a consequence of):		23i. Due to (or as a consequence of):		23j. Due to (or as a consequence of):	
	23k. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. HYPERTENSION ATRIAL FIBILLATION BREAST CA		23l. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23m. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23n. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 120333		29d. Date signed (Month, Day, Year) 3/11/00	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) K. ZOLVER MD 1838 GREEN TREE RD PIERCE MD							
	31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Page 1

1500

1500

1500

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09026

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara J. Thompson

2. Date of Death

Mar 12, 2000

3. Time of Death

6:45am

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore Co.

Funeral
Director

5. Social Security Number

219-62-2290

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 28, 1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3117 Crittenton Place

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Health Care

16b. Kind of Business/Industry

Roland Park Place

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Summa)

Betty White

19a. Informant's Name/Relationship (Type, Print)

Randall D. Thompson (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3117 Crittenton Place, Baltimore, Md 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lorraine Park Cemetery

Date

3/15/00

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.

3631 Falls Road, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

DR. TARIQ MAHMOOD

29c. License number

D43725

29d. Date signed (Month, Day, Year)

3/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Barbara Thompson March 12, 2000 6:45 A.M.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09027

AMEND#7 PER F.H. G781 3-18-2000 JAB

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Tate				2. Date of Death Month 3 Day 12 Year 2000		3. Time of Death 7:00pm	
	4a. Facility Name (If not institution, give street and number) Dulaney Townson HCR				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-44 5920		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 51 52 Yrs.		8. Date of Birth (Month, Day, Year) 3-2-48	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MARYLAND		10a. State Maryland		10b. County BALTIMORE	
To Be Completed by Funeral Director	10c. City, Town or Location WOODLAWN				10d. Inside City Limits 1 Yes 2 No			
	10e. Street and Number 7874 CORNERSTONE Way				10f. Zip Code 21244		10g. Citizen of What Country? USA	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: VIETNAM ERA		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade College (14 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Premier Messenger Service			
17. Father's Name (First, Middle, Last) JAMES Logan				18. Mother's Name (First, Middle, Maiden Surname) JULIA Tate				
19a. Informant's Name/Relationship (Type, Print) Vicky D. Tate / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7874 CORNERSTONE Way BALTIMORE, Maryland 21244				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville Veterans Cemetery		20c. Location - City or Town, State Crownsville, Maryland		
21. Signature of Funeral Service Licensee Greg Harris				22. Name and Address of Facility CHATHAM-HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21215				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. AIDS CRF						Approximate Interval Between Onset and Death MONTHS	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
	24a. Was an autopsy performed? 1 Yes 2 No						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier IRAN H. BALASUBRAMANIAN				29c. License number 152279		29d. Date signed (Month, Day, Year) 3/15/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRAN H. BALASUBRAMANIAN 4920 CAMPBELL BLVD MD 21236								
31. Date filed (Month, Day, Year) MAR 18 2000		32. Registrar's Signature James B. Sparks						

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

DONALD

State of Maryland / Department of Health and Mental Hygiene

00 09028

WILLIAMS JR. Amended Item#26 per MEO G781 3/20/2000 EW **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) (Aka Donald Lee Thompson) Donald Lee Williams, Jr.				2. Date of Death Month Day Year FEBRUARY 3, 2000		3. Time of Death 11:58A.M.		
	4a. Facility Name (If not institution, give street and number) 903 7th STREET				4b. City, Town, or Location of Death LAUREL		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 232-06-3192		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 26 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 8, 1973		
	9. Birthplace (State or Foreign Country) Beckley, WV		10a. State WV		10b. County Kanawha		10c. City, Town or Location So. Charleston		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 314 Central Avenue		10f. Zip Code 25303		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction					
17. Father's Name (First, Middle, Last) Donald Thompson, Jr.				18. Mother's Name (First, Middle, Maiden Surname) Sandra Echols					
19a. Informant's Name/Relationship (Type, Print) Sandra Woods - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Central Avenue So. Charleston, WV 25303					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenwood Memorial Park		20c. Date 2/9/00		20d. Location - City or Town, State Beckley, WV			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <u>Multiple gunshot wounds</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 2-3-2000		28b. Time of Injury 1115 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was shot by law enforcement officers	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 903 7th Street Prince Georges County, Maryland					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 4, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz		111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature <i>[Signature]</i>							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09029

AMENDED ITEMS 20b, 20c PER FH G782 4/12/2000 AH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAGGIE WOODS		2. Date of Death Month MARCH Day 17 Year 2000		3. Time of Death 0952 AM
	4a. Facility Name (If not institution, give street and number) ST. AGNES HEALTHCARE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
Funeral Director	5. Social Security Number 251 80 4733	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 9/28/38		9. Birthplace (State or Foreign Country) S.C.		
Usual Residence of Decedent					
10a. State MD.		10b. County		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 320 GRANTLEY ST.			10f. Zip Code 21229		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. AFRO Specify: AMERICAN					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry HOME	
17. Father's Name (First, Middle, Last) HAROLD WHITE SR.			18. Mother's Name (First, Middle, Maiden Surname) MARIE WHITE		
19a. Informant's Name/Relationship (Type, Print) EDWARD WOODS SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8136 MILFORD GARDEN DR. BALTO. MD. 21244		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of Kings cemetery, crematory or other place) KINGS MEMORIAL PARK		20c. Location - City or Town, State RANDALLSTOWN, MD	
20d. Date 3/22/2000		20e. Location - City or Town, State ELKRIDGE, MD.			
21. Signature of Funeral Service Licensee <i>Calvin Guy</i>			22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P. A. 1300 EUTAW PL BALTO. MD. 21217		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. acute myocardial infarction			Approximate Interval Between Onset and Death unknown
Due to (or as a consequence of):		b. atherosclerotic cardiovascular disease			unknown
Due to (or as a consequence of):		c.			
Due to (or as a consequence of):		d.			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hemorrhagic cerebrovascular accident					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Jon Falck MD</i>		29c. License number D47353		29d. Date signed (Month, Day, Year) March 17, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jon Falck MD ST. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229					
31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature <i>B. Sparks</i>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09030

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret E. Wild				2. Date of Death Month Day Year MARCH 17, 2000				3. Time of Death 4:35 AM		
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 218-36-0962		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) 10/26/1909		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 507A Castle Drive				10f. Zip Code 21212				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Christopher Gebhardt				18. Mother's Name (First, Middle, Maiden Surname) Anna Neubauger							
19a. Informant's Name/Relationship (Type, Print) Ms. Charlotte Wild/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 E. Belvedere Ave., Apt. C, Baltimore, MD 21239							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 03/19/00		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee Christina L. David Christina L. David				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CEREBROVASCULAR THROMBOSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 2 DAYS 2 DAYS	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Joginder P. Mehta M.D.				29c. License number D 41410				29d. Date signed (Month, Day, Year) March 17th, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204											
31. Date filed (Month, Day, Year) MAR 20 2000				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09031

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Elizabeth Xinos

2. Date of Death

Month
MarchDay
17Year
2000

3. Time of Death

0840A

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

216 16 4840

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Apr. 12, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

3419 Dunran Rd.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 yrs.

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

William Colison

18. Mother's Name (First, Middle, Maiden Sumame)

Olive Redmond

19a. Informant's Name/Relationship (Type, Print)

Asparia Kehm Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Torque Way Middle River, Md. 21220

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

Mar 20
2000

20c. Location - City or Town, State

Catonsville

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Rd. Dundalk, Md. 21222Physician
/Medical
Examiner23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

day(1)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samuel C. Durso, MD

29c. License number

D004704

29d. Date signed (Month, Day, Year)

March, 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel C. Durso, MD 4211 Blakely Ave. Suite 100 Baltimore, MD 21236

State
Registrar

31. Date filed (Month, Day, Year)

MAR 20 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09032

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Irene ABBOTT				2. Date of Death Month Day Year MAR 3 2000			3. Time of Death 4:10AM							
	4a. Facility Name (If not institution, give street and number) Coffman Nursing Home				4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington							
Funeral Director	5. Social Security Number 214-34-2329		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 31, 1914		9. Birthplace (State or Foreign Country) Virginia						
	Usual Residence of Decedent				10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown						
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 17016 Burwood Court				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry Her own home								
17. Father's Name (First, Middle, Last) Albin D. Kibler				18. Mother's Name (First, Middle, Maiden Surname) Annie Laura Chadduck											
19a. Informant's Name/Relationship (Type, Print) Mr. Leon P. Abbott - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12120 Hopewell Road, Hagerstown, Maryland 21740											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery		Date March 6, 2000		20c. Location - City or Town, State Hagerstown, Maryland							
21. Signature of Funeral Service Licensee Fred L. Vester				22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Liver cirrhosis Due to (or as a consequence of): b. Atherosclerotic heart disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 5 months 10 years					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, depression, Aortic stenosis, congestive heart failure										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier Samuel Chan		29c. License number D 36655		29d. Date signed (Month, Day, Year) March 3, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL CHAN, M.D. 1185 Mt Aetna Rd, Hagerstown, MD 21740										31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature P. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09033

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DORSEY CORLISS BRYAN		2. Date of Death Month MARCH Day 3 Year 2000		3. Time of Death 11:00 AM
	4a. Facility Name (If not institution, give street and number) 935 VALLEY ROAD		4b. City, Town, or Location of Death KNOXVILLE		4c. County of Death WASHINGTON
Funeral Director	5. Social Security Number 225-09-8127	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) FEB. 14, 1915		9. Birthplace (State or Foreign Country) WEST VIRGINIA		
To Be Completed by Funeral Director	10e. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location KNOXVILLE
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 935 VALLEY ROAD		10f. Zip Code 21758		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. WHITE		Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BRAKEMAN		16b. Kind of Business/Industry RAILROAD
	17. Father's Name (First, Middle, Last) DANIEL CLEVELAND BRYAN		18. Mother's Name (First, Middle, Maiden Surname) MATTIE (UMN) UPTON		
	19a. Informant's Name/Relationship (Type, Print) PAULINE L. BRYAN/SPOUSE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 935 VALLEY ROAD, KNOXVILLE, MARYLAND 21758		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BROWNSVILLE HEIGHTS CEM.		20c. Location - City or Town, State BROWNSVILLE, MARYLAND
	21. Signature of Funeral Service Licensee  Paul M. Dean		22. Name and Address of Facility BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alzheimer's dementia Due to (or as a consequence of):				Approximate Interval Between Onset and Death 3 yrs
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier  W. Huggins MD		29c. License number 016675		29d. Date signed (Month, Day, Year) 3/3/2000
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W. Huggins, DUNSWICK, MD 21716				
	31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature  B. Sparks		
	State Registrar				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G782 4-4-00 WR.

Certificate of Death

Reg. No.

00 09034

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) RONALD LEE ECKRICH		2. Date of Death Month Day Year March 12, 2000		3. Time of Death 6:10 P.M.	
4a. Facility Name (If not institution, give street and number) 16 Cypress Street		4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
5. Social Security Number 205-38-6474		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.	
8. Date of Birth (Month, Day, Year) July 2, 1948		9. Birthplace (State or Foreign Country) Pennsylvania			
Usual Residence of Decedent					
10a. State Md.		10b. County Washington		10c. City, Town or Location Hagerstown	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 16 Cypress St.		10f. Zip Code 21740	
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 64-75	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Manager		16b. Kind of Business/Industry Wine Distributor	
17. Father's Name (First, Middle, Last) John A. Eckrich Jr.		18. Mother's Name (First, Middle, Maiden Surname) Margaret M. Kelly			
19a. Informant's Name/Relationship (Type, Print) John A. Eckrich Jr. (Father)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Highland Ave. Shippensburg, Pa. 17257			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Location - City or Town, State March 14, 2000 Smithsburg, Md.	
21. Signature of Funeral Service Licensee Pennie L. Davis		22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) DIPHENHYDRAMINE INTOXICATION					
Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? Limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) FOUND: 3-12-00		28b. Time of Injury UNKNOWN	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT TOOK OVERDOSE OF DIPHENHYDRAMINE		28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 CYPRESS ST. HAGERSTOWN, WASHINGTON CO. MD	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) GARAGE OF RESIDENCE					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Stephen S. Radentz, MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 13, 2000	
30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) MAR 17 2000		32. Registrar's Signature B. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09035

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Steven Ray Fletcher

2. Date of Death

March 2 2000 5:20 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Western Maryland Hospital Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

215-64-0064

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 5, 1954

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13900 Pontius Lane

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Estimator

16b. Kind of Business/Industry

Sealing Co.

17. Father's Name (First, Middle, Last)

Lewis Milton Fletcher

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Sargent

19a. Informant's Name/Relationship (Type, Print)

Tammy L. Ware (Companion)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13900 Pontius Lane Hagerstown, Md. 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Mar. 3, 2000

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Davis Funeral Home
12525 Bradbury Ave.
Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Liver Disease

Due to (or as a consequence of):

b. Alcohollic Hepatitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatitis C

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rose Marie Chan, M.D.

29c. License number

D76416

29d. Date signed (Month, Day, Year)

March 2, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROSE MARIE CHAN, M.D. 1500 Pennsylvania Ave., Hagerstown MD 21742

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

MD 21742

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09036

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dillon Aloysius Flaherty, Jr.				2. Date of Death Month Day Year February 29, 2000				3. Time of Death 8:25 AM	
	4a. Facility Name (If not institution, give street and number) Future Care Chesapeake				4b. City, Town, or Location of Death Arnold				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 578-20-6774		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) August 7, 1923		9. Birthplace (State or Foreign Country) Johnstown, PA	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Queen Anne's		10c. City, Town or Location Stevensville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 511 Chesapeake Avenue				10f. Zip Code 21666				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printing Officer				16b. Kind of Business/Industry Defense/ Government		
17. Father's Name (First, Middle, Last) Dillon Aloysius Flaherty, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Kathryn V. Maher						
19a. Informant's Name/Relationship (Type, Print) Claire E. Flaherty / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Chesapeake Ave. Stevensville, MD 21666						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation		Date March 6, 2000		20c. Location - City or Town, State Chester, MD				
21. Signature of Funeral Service Licensee <i>Chad M. Hefner</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd. Chester, MD 21619						
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>pneumonia</i> Due to (or as a consequence of): <i>chronic obstructive pulmonary disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>diabetes, dementia, hypertension, osteoporosis</i>								Approximate Interval Between Onset and Death <i>days</i> <i>years</i>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>diabetes, dementia, hypertension, osteoporosis</i>								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Rebecca Elton MD</i>		29c. License number D41955		
29d. Date signed (Month, Day, Year) 2-29-00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca Elton MD 479 Jumpers Hole Rd #304 Swerra Park MD 21146		31. Date filed (Month, Day, Year) MAR 02 2000		32. Registrar's Signature <i>B. Spauld</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09037

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SYLVIA

MAY

GRIMES

2. Date of Death

MARCH

Day

6

Year

2000

3. Time of Death

1:47 PM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

216-30-4026

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 3, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Brandywine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16209 Ashbox Road

10f. Zip Code

20613

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Equipment Analyst

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

William Murphy Oliver

18. Mother's Name (First, Middle, Maiden Surname)

Cora Taylor

19a. Informant's Name/Relationship (Type, Print)

O. Walton Grimes/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16209 Ashbox Road, Brandywine, Maryland 20613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Memorial Gardens

Date

03-09-2000

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

MARK G. BROHAWN

M00053

22. Name and Address of Facility

The Hunt Funeral Home, Inc.

P. O. Box 156, Waldorf, Maryland 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SUDDEN CARDIAC DEATH

Due to (or as a consequence of):

b. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

c. OLD ANTEROLATERAL MYOCARDIAL INFARCT

Due to (or as a consequence of):

d. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SINUS POST CORONARY ARTERY BYPASS SURGERY

UNCONTROLLED DIABETES MELLITUS

HYPERHOMOCYSTEINEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. B. Baroszyk

29c. License number

D39909

29d. Date signed (Month, Day, Year)

3-6-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. B. BAROSZYK MD FACC

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

B. Spauld

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09038

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Carolene Heare

2. Date of Death

March

Day

5

3. Time of Death

10:23 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

203-12-2090

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 18, 1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14225 Oak Springs Rd.

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Inspector

16b. Kind of Business/Industry

Aircraft

17. Father's Name (First, Middle, Last)

Walter Shanholtz

18. Mother's Name (First, Middle, Maiden Surname)

Mae Haines

19a. Informant's Name/Relationship (Type, Print)

Roger E. Heare Sr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14225 Oak Springs Rd. Hagerstown, Md. 21742

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

March 7, 2000

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Davis Funeral Home
12525 Bradbury Ave.
Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic respiratory failure
Multi Organ Failure
Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.

29b. Signature and title of certifier

29c. License number

D41786

29d. Date signed (Month, Day, Year)

3/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Alenchery MD, 12821 Oak Hill Ave, Hagerstown MD 21742

State
Registrar

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Heare, Elizabeth

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09039

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Geneva Virginia LUMM				2. Date of Death Month Day Year March 6 2000		3. Time of Death 00 35	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 218-24-1792	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	8. Date of Birth (Month, Day, Year) Sept 24 1927	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent		10a. State Maryland		10b. County Washington		10c. City, Town or Location Williamsport	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 111 West Potomac Street Apt. 2		10f. Zip Code 21795		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Her own home				
17. Father's Name (First, Middle, Last) Carmen Younkings				18. Mother's Name (First, Middle, Maiden Surname) Ruth Morgan				
19a. Informant's Name/Relationship (Type, Print) Virginia Smith - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6631 Dam #4 Road Sharpsburg, Md. 21782				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory 3/7/00		20c. Location - City or Town, State Hagerstown, Maryland				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiorespiratory Failure</i>		Due to (or as a consequence of): b. <i>Chronic Obstructive Pulmonary Disease</i>		Due to (or as a consequence of): c. <i>Hypertension by History</i>		Due to (or as a consequence of): d. <i>Acute Pneumonia/Bronchitis</i>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e. <i>Ischemic Heart Disease</i>		f. <i>Osteoporosis severe</i>		g. <i>Arthritis</i>		Approximate Interval Between Onset and Death Few days		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ischemic Heart Disease</i> <i>Osteoporosis severe</i> <i>Arthritis</i>				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D35497		29d. Date signed (Month, Day, Year) 3-6-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.A. PASHA, MD 376 Mill Street Hagerstown MD 21740								
31. Date filed (Month, Day, Year) MAR 9 8 2000		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09040

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MEYER (NMN) LAHN

2. Date of Death

March 6 2000

3. Time of Death
9:35 AMFuneral
Director

4a. Facility Name (If not institution, give street and number)

Fahrney-Keedy Memorial Home Boonsboro

4b. City, Town, or Location of Death

4c. County of Death

Washington

5. Social Security Number

214-03-7964

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 2, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

911 Dewey Avenue

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stress Analysis

16b. Kind of Business/Industry

Mfg. of Cranes

17. Father's Name (First, Middle, Last)

Louis

Lahn

18. Mother's Name (First, Middle, Maiden Surname)

Daisy

Spikloser

19a. Informant's Name/Relationship (Type, Print)

Beatrice R. Lahn Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

911 Dewey Avenue, Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

B'Nai Abraham Cemetery 03-07-2000

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

R.heel Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.

40 East Antietam Street, Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Dehydration

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

Dyspnea

10 min

c.

Due to (or as a consequence of):

Central venous catheter

10 min

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vasant Datta

29c. License number

D18015

29d. Date signed (Month, Day, Year)

MARCH 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vasant Datta M.D. 334 Mill Street, Hagerstown, Maryland 21740

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Lahn, Meyer

Lahn, Meyer

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09041

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Agnes Martha Marshall				2. Date of Death Month Day Year February 24, 2000				3. Time of Death 6:15 p.m.	
	4a. Facility Name (If not institution, give street and number) Spa Creek				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 217-30-7876		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) April 29, 1908		9. Birthplace (State or Foreign Country) Maryland	
	10a. State Maryland				10b. County Queen Anne's		10c. City, Town or Location Chester		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 303 Dominion Lane				10f. Zip Code 21619		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) 4 Elementary/Secondary (0-12) Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Homemaker			
	17. Father's Name (First, Middle, Last) James E. Long				18. Mother's Name (First, Middle, Maiden Surname) Katherine E. Lemline					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Elsie Mae Dill / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Dominion Lane Chester, Maryland 21619					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Stevensville Cemetery February 28, 2000 Stevensville, MD		20c. Location - City or Town, State					
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Chad M. Helfenbein				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd. Chester, MD 21619					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Heart Failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 weeks					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature] MD		29c. License number D 38458		29d. Date signed (Month, Day, Year) 2/28/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dafet Singh Kelly 11613 Annapolis Road #106 Odenton MD 21113									
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) MAR 01 2000		32. Registrar's Signature [Signature]							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09042

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Doris Evelyn Moore</i>				2. Date of Death Month <i>March</i> Day <i>7</i> , Year <i>2000</i>				3. Time of Death <i>9:40 A.M.</i>													
	4a. Facility Name (If not institution, give street and number) <i>14220 Royer Rd.</i>				4b. City, Town, or Location of Death <i>Cascade</i>				4c. County of Death <i>Washington</i>													
Funeral Director	5. Social Security Number <i>168-26-4961 A</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>80</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Feb. 11, 1920</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>													
	Usual Residence of Decedent																					
10a. State <i>Md.</i>		10b. County <i>Washington</i>		10c. City, Town or Location <i>Cascade</i>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
10e. Street and Number <i>25407 Military Rd.</i>				10f. Zip Code <i>21719</i>				10g. Citizen of What Country? <i>U.S.A.</i>														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>														
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Clerk</i>				16b. Kind of Business/Industry <i>Store</i>														
17. Father's Name (First, Middle, Last) <i>Walter J. Olsen</i>				18. Mother's Name (First, Middle, Maiden Summa) <i>Zula H. Eyler</i>																		
19a. Informant's Name/Relationship (Type, Print) <i>Frank O. Moore Sr (Husband)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>25407 Military Rd. Cascade, Md. 21719</i>																		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Smithsburg Crematory</i>				20c. Location - City or Town, State <i>Smithsburg, Md.</i>														
21. Signature of Funeral Service Licensee <i>Bennis R. Davis</i>				22. Name and Address of Facility <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td><i>Carcinomatosis</i></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Carcinomatosis</i>	Due to (or as a consequence of):	b.		Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Carcinomatosis</i>	Due to (or as a consequence of):																			
	b.		Due to (or as a consequence of):																			
	c.		Due to (or as a consequence of):																			
	d.		Due to (or as a consequence of):																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Daughter's home</i>																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier <i>Diana Syllabus MD</i>				29c. License number <i>MD 03084E</i>				29d. Date signed (Month, Day, Year) <i>March 8, 2000</i>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Diana Syllabus MD 369 Mont Alto Rd 17237</i>																						
31. Date filed (Month, Day, Year) <i>MAR 10 2000</i>				32. Registrar's Signature <i>B. Sparks</i>																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09043

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Forbes Macpherson, Sr.

2. Date of Death

March 6, 2000

Day

Year

3. Time of Death

2123

4a. Facility Name (If not Institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

220-16-2314

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 23, 1919

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20009 Rosebank Way Apt. 109

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Senior Buyer

16b. Kind of Business/Industry

Mack Truck

17. Father's Name (First, Middle, Last)

William Smith Macpherson

18. Mother's Name (First, Middle, Maiden Surname)

Helen Forbes

19a. Informant's Name/Relationship (Type, Print)

Melissa A. Gaines

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

842 Mulberry Avenue Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hagerstown Crematory

Date

3/9/00

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Gerald N. Minnich

22. Name and Address of Facility

Gerald N. Minnich 305 N. Potomac Street
Funeral Home Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)a. Acute myocardial infarction
Due to (or as a consequence of):

minutes

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Coronary Artery Disease
Due to (or as a consequence of):

Decade

c. Diabetes mellitus, Type 1
Due to (or as a consequence of):

Decade

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Aortic Stenosis
Left Ventricular Failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier

FAMILY PHYSICIAN

29c. License number

D 17067

29d. Date signed (Month, Day, Year)

3/8/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Metzner 747 Northern Ave. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

*B. Sparks*State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 09044

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willis Solomon MARTIN				2. Date of Death Month Day Year MAR 3 2000		3. Time of Death 3:50AM	
	4a. Facility Name (If not institution, give street and number) Coffman Nursing Home				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 217-32-5631		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 2, 1902	
	10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Usual Residence of Decedent								
10e. Street and Number 104 East First Street				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-3 College (14 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) dairy man			16b. Kind of Business/Industry dairy processor	
17. Father's Name (First, Middle, Last) Eli Martin				18. Mother's Name (First, Middle, Maiden Surname) Lucy Weaver				
19a. Informant's Name/Relationship (Type, Print) Mr. Jack W. Martin - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19826 Bennie Drive, Hagerstown, Maryland 21742				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date March 3, 2000		20c. Location - City or Town, State Hagerstown, Maryland
21. Signature of Funeral Service Licensee Fred L. Weaver				22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic heart disease</u> Due to (or as a consequence of): b. <u>Coronary heart failure</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Stroke</u> <u>peripheral vascular disease</u>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier Samuel Chan				29c. License number D36655		29d. Date signed (Month, Day, Year) March 3, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL CHAN 1185 Mt Aetna Rd Hagerstown, MD 21740								
31. Date filed (Month, Day, Year) MAR 06 2000				32. Registrar's Signature B. Sparks				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09045

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Webster Martin				2. Date of Death Month March Day 3 Year 2000		3. Time of Death 9:13am	
	4a. Facility Name (If not institution, give street and number) Williamsport Nursing Home				4b. City, Town, or Location of Death Williamsport		4c. County of Death Washington	
Funeral Director	5. Social Security Number 220-09-7804	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 15, 1913		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Washington		10c. City, Town or Location Big Pool			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 10433 National Pike			10f. Zip Code 21711		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th grade College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner/operator			16b. Kind of Business/Industry grocery store		
	17. Father's Name (First, Middle, Last) Lloyd W. Martin				18. Mother's Name (First, Middle, Maiden Surname) Lottie L. Hart			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Anna M. Martin spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10433 National Pike Big Pool, MD 21711			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul Cem. March 6, 2000		Date March 6, 2000		20c. Location - City or Town, State Clear Spring, MD	
	21. Signature of Funeral Service Licensee <i>Donald M. Fink</i>				22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc P.O. Box 310 Clear Spring, MD. 21722			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Aspiration Due to (or as a consequence of): c. Possible Parkinsons Disease Due to (or as a consequence of): d. Approximate Interval Between Onset and Death two weeks weeks unknown							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Cynthia Kuttner-Sands, MD		29c. License number D47451		29d. Date signed (Month, Day, Year) March 3, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Kuttner-Sands, MD 11110 Medical Campus Road, Suite 130, Hagerstown, Maryland 21742								
31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

00 09046

1 - FOR STATE REGISTRAR AMEND ITEM 5 per inf G794 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 4/11/01 REG. NO. SS

1. DECEDENT'S NAME (First, Middle, Last) Lucy Belle MUNCH				2. DATE OF DEATH MONTH March DAY 1 YEAR 2000				3. TIME OF DEATH 7:00 A M	
4. SOCIAL SECURITY NUMBER 215-42-3718 553-16-9362		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 90 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 18 1909		8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not institution, give street and number) 11210 Greenberry Road				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington	
10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11210 Greenberry Road				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Public School System					
17. FATHER'S NAME (First, Middle, Last) John A.G. Clem				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Susan Henry					
19a. INFORMANT'S NAME (Type/Print) Eric Munch - Son				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4263 Leitersburg Road Waynesboro, Pa. 17268					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Panorama Memorial Gardens		DATE 3/5/00		20c. LOCATION — City or Town, State Waterlick, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Fred L. Vester				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerosis								Approximate Interval Between Onset and Death unknown	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Samuel Chan		29c. LICENSE NUMBER D36055		29d. DATE SIGNED (Month, Day, Year) March 3, 2000			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1185 MT AETNA RD, HAGERSTOWN, MD 21740									
31. DATE FILED (Month, Day, Year) MAR 06 2000		32. REGISTRAR'S SIGNATURE P. Sparks							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09047

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHAEL LEE MYERS				2. Date of Death Month Day Year MARCH 7, 2000		3. Time of Death 12:30AM	
	4a. Facility Name (If not institution, give street and number) 2109 Gibbons Court				4b. City, Town, or Location of Death Waldorf		4c. County of Death Charles	
Funeral Director	5. Social Security Number 217-42-0505		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) June 24, 1946	
	9. Birthplace (State or Foreign Country) Washington, DC							
Usual Residence of Decedent								
10a. State MD		10b. County Charles		10c. City, Town or Location Waldorf				10d. Inside City Limits 1 Yes 2 X No
10e. Street and Number 2109 Gibbons Court				10f. Zip Code 20602		10g. Citizen of What Country? USA		
11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat Manager			16b. Kind of Business/Industry Food Store	
17. Father's Name (First, Middle, Last) Samuel Myers				18. Mother's Name (First, Middle, Maiden Surname) Margaret Myers				
19a. Informant's Name/Relationship (Type, Print) Mary Myers/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2109 Gibbons Ct. Waldorf, MD. 20602				
20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols FH		20c. Location - City or Town, State 3/10/00 Charlotte Hall, MD		
21. Signature of Funeral Service Licensee David C. Echols M00945				22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon CA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown		
						24a. Was an autopsy performed? 1 Yes 2 X No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No
25. Was case referred to medical examiner? 1 Yes 2 X No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 X No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Kevin M. Hatten				29c. License number D28352		29d. Date signed (Month, Day, Year) 3/7/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, MD 3500 Old Washington Rd Waldorf MD 20602								
31. Date filed (Month, Day, Year) MAR 09 2000				32. Registrar's Signature Bernice G. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09048

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARENCE MATTHEW MERRYMAN

2. Date of Death

March 6, 2000

3. Time of Death

10:25 AM

4a. Facility Name (If not institution, give street and number)

Charles County Nursing Home

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

718-14-9297

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 8, 1913

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

10200 La Plata Road

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Matthew Merryman

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Loffler

19a. Informant's Name/Relationship (Type, Print)

Joseph R. Merryman - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

214 Morgans Ridge Ct., La Plata, MD 20646

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

3-10-00

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Mark G. Brohawn M00053

22. Name and Address of Facility

Huntt Funeral Home, Inc.
P O Box 156, Waldorf, MD 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. LEFT LOWER LOBE PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ADVANCED ALZHEIMERS DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Fredrick M. Johnson M.D.

29c. License number

D06704

29d. Date signed (Month, Day, Year)

3-9-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDERICK M. JOHNSON M.D. PO Box 460 LA PLATA MD 20646

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

Benita B. Spaw

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09049

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Paul William Mullenix, SR

2. Date of Death

March 01 2000

3. Time of Death

0655

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-28-8845

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 17, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11145 Lakeside Dr.

10f. Zip Code

21740

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Insurance Salesman

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Paul Russell Mullenix

18. Mother's Name (First, Middle, Maiden Surname)

Mary Painter

19a. Informant's Name/Relationship (Type, Print)

Marjorie A. Mullenix / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11145 Lakeside Dr. Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

3-6-2000

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1601 Pennsylvania Ave.

Rest Haven Funeral Chapel Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sudden Cardiac Death

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

few min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Anterior wall Myocardial Infarction

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D18019

29d. Date signed (Month, Day, Year)

MARCH 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VASANT DATTA, M.D. 334 MILL ST HAGERSTOWN, MD 21740

31. Date filed (Month, Day, Year)

MAR 02 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09050.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Franklin Ryon				2. Date of Death Month Day Year February 27, 2000				3. Time of Death 5:15 PM	
	4a. Facility Name (If not institution, give street and number) 406 Queen Anne Club Drive				4b. City, Town, or Location of Death Stevensville				4c. County of Death Queen Anne's	
Funeral Director	5. Social Security Number 216-16-0082		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) January 6, 1921		9. Birthplace (State or Foreign Country) Washington DC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Queen Anne's		10c. City, Town or Location Stevensville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 406 Queen Anne Club Drive				10f. Zip Code 21666		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Banker			16b. Kind of Business/Industry Banking		
	17. Father's Name (First, Middle, Last) John Wilson Ryon				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth J. Bryan					
	19a. Informant's Name/Relationship (Type, Print) Edna Lohmann Ryon / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Queen Anne Club Dr. Stevensville, MD 21666					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center		20c. Location - City or Town, State 2-28-00 Stevensville					
	21. Signature of Funeral Service Licensee Chad M. Helfenbein				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd. Chester, MD 21619					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1M									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										
28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 29c. License number 032036 29d. Date signed (Month, Day, Year) 2/28/00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gay J. Sprase 2108 S. Dantz Drive Ch. Co. Mo 64619										
31. Date filed (Month, Day, Year) MAR 01 2000 32. Registrar's Signature B. Sparks										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Chesapeake Cremation Center 28-00 Stevensville

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09051

Certificate of Death

Reg. No.

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) <u>Evelyn May SHILLING</u>				2. Date of Death Month <u>MARCH</u> Day <u>6</u> Year <u>2000</u>		3. Time of Death <u>0910</u>	
	4a. Facility Name (If not institution, give street and number) <u>Washington County Hospital</u>				4b. City, Town, or Location of Death <u>Hagerstown</u>		4c. County of Death <u>Washington</u>	
Funeral Director	5. Social Security Number <u>220-16-2965</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>78</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Dec. 5 1921</u>		9. Birthplace (State or Foreign Country) <u>Pennsylvania</u>
	Usual Residence of Decedent							
10a. State <u>Maryland</u>		10b. County <u>Washington</u>		10c. City, Town or Location <u>Hagerstown</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <u>1334 Potomac Avenue Apt. 26</u>				10f. Zip Code <u>21742</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>0-8</u> College (1-4or 5+) <u>0</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Supervisor - Personnel</u>		16b. Kind of Business/Industry <u>Department Store</u>		
17. Father's Name (First, Middle, Last) <u>Isaac Heckman</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Grace Freeze</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Cassandra Babineau-Daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>11015 Parkwood Drive Hagerstown, Maryland 21740</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cedar Lawn Memorial Park</u>		Date <u>3/9/00</u>		20c. Location - City or Town, State <u>Hagerstown, Maryland</u>		
21. Signature of Funeral Service Licensee <u>Scott M. Minnick</u>				22. Name and Address of Facility <u>Minnich Funeral Home</u> <u>415 E. Wilson Blvd. Hagerstown, Maryland 21740</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Cardiopulmonary Arrest</u> Due to (or as a consequence of): <u>Chronic obstructive Pulmonary Disease</u> Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Coronary Artery Disease</u> <u>Diabetes Mellitus</u> <u>Hypertension</u>								Approximate Interval Between Onset and Death <u>few min</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Heart Failure, Arteriosclerosis</u> <u>Cardiovascular Disease</u> <u>Diabetes Mellitus</u> <u>Hypertension</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <u>M</u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Scott M. Minnick</u>		29c. License number <u>D18019</u>		29d. Date signed (Month, Day, Year) <u>MARCH 6, 2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>VASANT DATTA, MD 334 MILL ST HAGERSTOWN, MD 21740</u>								
31. Date filed (Month, Day, Year) <u>MAR 08 2000</u>		32. Registrar's Signature <u>B. Sparks</u>						

ORIGINAL

NAME: SHILLING, EVELYN MAY
12/05/1921 78 / F
DATA, VASANT
DOS: 02/21/2000



H3041313226



H056908

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09052

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Howard SHANK				2. Date of Death Month Day Year March 4 2000		3. Time of Death 1805	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 219-05-2104		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) March 16 1910	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1305 Outer Drive		10f. Zip Code 21742		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Trucking		17. Father's Name (First, Middle, Last) Jacob Henry Shank	
	18. Mother's Name (First, Middle, Maiden Surname) Claire Shives		19a. Informant's Name/Relationship (Type, Print) Donna Rigglesman -G. Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 3 Box 31 Charles Town, W. Va. 25414		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery		20c. Date 3/10/00		20d. Location - City or Town, State Hagerstown, Maryland		21. Signature of Funeral Service Licensee <i>Scott M. Minnich</i>	
	22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <i>Arteriosclerotic heart disease</i> Due to (or as a consequence of): b. <i>Generalized arteriosclerosis</i> Due to (or as a consequence of): c. <i>Cerebrovascular insufficiency</i> Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death yes yes		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27a. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		27b. Date of Injury (Month, Day Year) M		27c. Time of Injury M		27d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Location (Street and Number or Rural Route Number, City or Town, State)	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Harold M. ...</i>	
To Be Completed by Physician/Medical Examiner	29c. License number D 12 194		29d. Date signed (Month, Day, Year) mar 6 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Trutch 348 Mill St. Hagerstown, md. 21740		31. Date filed (Month, Day, Year) MAR 08 2000	
	32. Registrar's Signature <i>B. Sparks</i>		33. Registrar's Signature <i>B. Sparks</i>		34. Registrar's Signature <i>B. Sparks</i>		35. Registrar's Signature <i>B. Sparks</i>	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09053

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALICE ELIZABETH SHRADER				2. Date of Death Month March Day 3 Year 2000		3. Time of Death 7:20 AM		
	4a. Facility Name (If not institution, give street and number) 304 Westside Avenue				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington		
Funeral Director	5. Social Security Number 217-28-1284		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) August 28, 1932		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 304 Westside Avenue		10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner and Operator		16b. Kind of Business/Industry Sub Shop					
17. Father's Name (First, Middle, Last) Antonio Pennesi				18. Mother's Name (First, Middle, Maiden Surname) Giovanna Grasonni					
19a. Informant's Name/Relationship (Type, Print) Robert C. Shrader Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Westside Avenue, Hagerstown, Maryland 21740					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park		20c. Location - City or Town, State 03-06-2000 Hagerstown, Maryland					
21. Signature of Funeral Service Licensee R. Noel Brady				22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. Lung Cancer Due to (or as a consequence of):		f. 7 year					
b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Michael J. McCormack MD.		29c. License number 041667		29d. Date signed (Month, Day, Year) 3-3-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. McCormack 11110 Medical Campus Rd. Hagerstown MD 21742									
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09054

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Reba Jane Shank					2. Date of Death Month Day Year MARCH 3 2000			3. Time of Death 2:00 AM		
	4a. Facility Name (If not institution, give street and number) Western Maryland Hospital Center					4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington		
Funeral Director	5. Social Security Number 215-20-8038		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 3, 1928		9. Birthplace (State or Foreign) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Md.		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 1038 Brinker Dr.				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Clerk			16b. Kind of Business/Industry Court House				
	17. Father's Name (First, Middle, Last) Calvert C. Stottlemeyer					18. Mother's Name (First, Middle, Maiden Surname) Maude L. Eccard					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Penny K. Petrie (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1030 Brinker Dr. #202 Hagerstown, Md. 21740					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park		Date March 8, 2000		20c. Location - City or Town, State Hagerstown, Md.				
	21. Signature of Funeral Service Licensee Dennis L. Davis					22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. HIP FRACTURE Due to (or as a consequence of): c. FALL Due to (or as a consequence of): d.									DAYS 41 MONTHS 4 MONTHS	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, TRANSIENT ISCHEMIC ATTACKS, GASTROESOPHAGEAL REFLUX DISEASE								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> NO		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> NO								
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 11-05-99		28b. Time of Injury UNKNOWN		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred FALL		
	28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify) AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) HAGERSTOWN, MD								
State Registrar	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier MD		29c. License number 048622		29d. Date signed (Month, Day, Year) MARCH 3, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRADY HENCONIN MD, 19236 MERRIMAN VIEW DR. HAGERSTOWN MD 21742										
	31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature P. Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09055

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GRACE SMITH

2. Date of Death

March 3 2000

3. Time of Death

5:27am

4e. Facility Name (If not institution, give street and number)

Copper Ridge

4b. City, Town, or Location of Death

SYKESVILLE

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

370-58-6121

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 7, 1907

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10e. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

710 Obrecht Road

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Henry L. Glaser

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Peters

19e. Informant's Name/Relationship (Type, Print)

Ronald Smith (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2078 St. James Rd., Marriotsville, Md. 21104

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Sepulchre Cemetery

Date

Mar 6, 2000

20c. Location - City or Town, State

Southfield, MI.

21. Signature of Funeral Service Licensee

M-00849

Paul T. Hochstetler

22. Name and Address of Facility

Inman Nationwide Shipping

6500 Merwin Ave., Cleveland, Oh.

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End Stage Alzheimer's Disease

Approximate Interval Between Onset and Death

years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ernestine Wright, MD

29c. License number

D52740

29d. Date signed (Month, Day, Year)

March 3rd 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

710 Obrecht Road Sykesville, MD 21784

31. Date filed (Month, Day, Year)

MAR 10 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10cc

1000 mg

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09056

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elvena May Stevens				2. Date of Death Month March Day 2 Year 2000		3. Time of Death 06:15	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 215-16-6372		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) Jan. 8, 1915	9. Birthplace (State or Foreign Country) Penna.
	Usual Residence of Decedent							
10a. State PA.		10b. County Franklin		10c. City, Town or Location Greencastle			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 4215 Sportsman Rd.				10f. Zip Code 17225		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Emanuel Hayes				18. Mother's Name (First, Middle, Maiden Surname) Florence Wax				
19a. Informant's Name/Relationship (Type, Print) Wilson Stevens / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4215 Sportsman Rd. Greencastle, Pa. 17225				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Welsh Run Church of The Brethren Cemetery		Date 3/6/2000		20c. Location - City or Town, State Welsh Run, Pa.		
21. Signature of Funeral Service Licensee H. Martin Zimmerman Sr.				22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number D52323		29d. Date signed (Month, Day, Year) 3/8/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELVENA M. WACKEM 21944 C LITERSBURG PIKE HAGERSTOWN MD 21794								
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09057

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Mary Shaw

2. Date of Death

March 1 2000

3. Time of Death

3:30 a.m.

4a. Facility Name (If not institution, give street and number)

Colton Villa Nursing Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

229-01-3589

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 27 1914

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Monrovia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3903 Millstone Circle

10f. Zip Code

21770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her own home

17. Father's Name (First, Middle, Last)

John Kerns

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Hitt

19a. Informant's Name/Relationship (Type, Print)

Gail Shaw Orr

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3903 Millstone Circle Monrovia, Md. 21770

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

3/2/00

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

James L. Spicer

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic CARDIOVASCULAR DISEASE

MINS

Due to (or as a consequence of):

b. ASPIRATION PNEUMONIA

2 weeks

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Maryann J. Haff

29c. License number

D28365

29d. Date signed (Month, Day, Year)

3-1-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MTAN 2 AR J. SHAW 368 MILL STREET HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

MAR 02 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09058

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Maxine TRACY				2. Date of Death Month 3 Day 3 Year 00		3. Time of Death 7:10
	4a. Facility Name (If not institution, give street and number) Avalon Manor				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington
Funeral Director	5. Social Security Number 212-14-7090	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 13, 1921	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Washington	10c. City, Town or Location Hagerstown		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 725 Spruce Street			10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-10 College (14 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry her own home		
	17. Father's Name (First, Middle, Last) Douglas Weaver			18. Mother's Name (First, Middle, Maiden Surname) Ruth Humelsine			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Richard Tracy - son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6704 Christmas Berry Court, Middletown, Maryland 21769			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. View Cemetery		Date March 6, 2000	20c. Location - City or Town, State Sharpsburg, Maryland	
	21. Signature of Funeral Service Licensee Fred L. Untal			22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma cerv upper lobe Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death 1 year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive Pulmonary disease Diabetes Mellitus Coronary Artery Disease Hypertension						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Dr. Vasant Datta				29c. License number D18019		29d. Date signed (Month, Day, Year) MARCH 3, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vasant Datta 334 millst Hagerstown, Maryland 21740							
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09059

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Weeks

2. Date of Death

February 29, 2000

3. Time of Death

5:40 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

225-54-9374

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

October 31, 1943

9. Birthplace (State or Foreign Country)

Radford, VA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne's

10c. City, Town or Location

Chester

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

1837 Harbor Drive

10f. Zip Code

21619

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Customer Service

16b. Kind of Business/Industry

Airlines

17. Father's Name (First, Middle, Last)

Sayford Jackson Weeks

18. Mother's Name (First, Middle, Maiden Surname)

Mary Fisher

19a. Informant's Name/Relationship (Type, Print)

Brenda B. Weeks / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1837 Harbor Dr. Chester, MD 21619

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Cremation Center Feb. 29, 2000 Chester, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Maurice A. Freeman

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home
106 Shamrock Rd. Chester, MD 2161923a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. ischemic cardiomyopathy

15 Years

Due to (or as a consequence of):

b. Coronary atherosclerotic heart disease

15 Years

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple sclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H. D. Goldstein M.D.

29c. License number

D26743

29d. Date signed (Month, Day, Year)

2/29/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

H. D. Goldstein M.D. 205 Ridgely Ave Annapolis Md.

State
Registrar

31. Date filed (Month, Day, Year)

MAR 02 2000

32. Registrar's Signature

Geneva B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09060

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROY EDWARD WARREN				2. Date of Death Month Day Year MARCH 07 2000		3. Time of Death 0614	
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 219 07 2521	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT 11, 1911		9. Birthplace (State or Foreign Country) Adams Co. PA
	Usual Residence of Decedent							
10a. State MD		10b. County WASHINGTON		10c. City, Town or Location CASCADE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 25444 HIGHFIELD RD				10f. Zip Code 21719		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST		16b. Kind of Business/Industry TOOL MFG		
17. Father's Name (First, Middle, Last) CHARLES F WARREN				18. Mother's Name (First, Middle, Maiden Surname) SARAH TRESSLER				
19a. Informant's Name/Relationship (Type, Print) BETSY Y. BAKER DAUGH				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 WHITE OAK TR FAIRFIELD PA 17320				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BETHEL CHURCH CEM.		20c. Location - City or Town, State MAR 10 CASCADE, MD		
21. Signature of Funeral Service Licensee James A. Bowersox				22. Name and Address of Facility Grove Funeral Home, Inc. 50 S Broad St Waynesboro Pa 17268				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bronchogenic Carcinoma Due to (or as a consequence of): b. Chronic obstructive pulmonary disease Due to (or as a consequence of): c. Coronary Artery disease Due to (or as a consequence of): d.								
Approximate Interval Between Onset and Death (6) Months unknown unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MD				29c. License number D47288		29d. Date signed (Month, Day, Year) 03, 8, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Iqbal 12821 Oak Hill Avenue Hagerstown Maryland								
31. Date filed (Month, Day, Year) MAR 09 2000				32. Registrar's Signature Bevera G. Sparks				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09061

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herbert Marion Wenner				2. Date of Death Month Day Year March 5 2000		3. Time of Death 8:30 AM	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 215-34-0879		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 01/21/1937	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location BOONSBORO		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 6413 OLD NATIONAL PIKE				10f. Zip Code 21713		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1954-1957		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 YEARS				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEEL WORKER		16b. Kind of Business/Industry STEEL MANUFACTURE		
17. Father's Name (First, Middle, Last) HERBERT MALCOM WENNER				18. Mother's Name (First, Middle, Maiden Surname) BESSIE M. GROVE				
19a. Informant's Name/Relationship (Type, Print) GLORIA V. WENNER/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6413 OLD NATIONAL PIKE, BOONSBORO, MARYLAND 21713				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY 03/08/2000		20c. Location - City or Town, State BOONSBORO, MARYLAND		
21. Signature of Funeral Service Licensee P. STEVEN DANFELT, JR.				22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 21713				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. Intracerebral bleed					Approximate Interval Between Onset and Death 12 hrs.	
		Due to (or as a consequence of):						
		b. Hypertension					years	
		Due to (or as a consequence of):						
		c.						
		Due to (or as a consequence of):						
		d.						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal cancer								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier P. Steven Danfelt, Jr.				29c. License number D50813		29d. Date signed (Month, Day, Year) Mar 5, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. J. O'Malley 11110 Medical Campus Rd Hagerstown, MD 21742								
31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Wenner, Herbert Marion

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09062

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAGDALEN ELEANOR WEBB

2. Date of Death

March 2 2000 09:50

3. Time of Death

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

Funeral
Director

5. Social Security Number

502 14 9137

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 30, 1924 St Anthony, ND

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

PA

10b. County

FRANKLIN

10c. City, Town or Location

WAYNESBORO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

111 LANDIS AVE

10f. Zip Code

17268

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Bleck, White, etc.
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SALES CLERK

16b. Kind of Business/Industry

RETAIL STORES

17. Father's Name (First, Middle, Last)

NICKLAUS V. HELBLING

18. Mother's Name (First, Middle, Maiden Surname)

SUSIE BRAUN

19a. Informant's Name/Relationship (Type, Print)

ALBERT F. WEBB NUSB

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 LANDIS AVE WAYNESBORO PA 17268

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St Andrew Church Cem.

Date

MAR 4

20c. Location - City or Town, State

WAYNESBORO, PA

21. Signature of Funeral Service Licensee

James A. Bowersox

22. Name and Address of Facility

GROVE FUNERAL HOME INC
50 S BROAD ST WAYNESBORO PA 17268

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiorespiratory Arrest

Due to (or as a consequence of):

b. Respiratory Failure

Due to (or as a consequence of):

c. End Stage Renal Failure

Due to (or as a consequence of):

d. Arteriosclerotic Cardiovascular Disease

Approximate Interval Between Onset and Death

1 Week

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke Cerebral artery
Severe stenosis with ulceration
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

C. A. Sullivan

29c. License number

D18127

29d. Date signed (Month, Day, Year)

3/4/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

C. A. Sullivan MD 370 Mill St. Hagerstown Md 21740

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09063

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EARL K BOGGS, SR				2. Date of Death Month 03 Day 17 Year 2000		3. Time of Death 3:12 AM	
	4a. Facility Name (If not institution, give street and number) VA HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a	
Funeral Director	5. Social Security Number 237-20-2893		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 29, 1916	9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
10a. State Maryland		10b. County Howard		10c. City, Town or Location Elkridge			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. Street and Number 6333 Beechfield Avenue				10f. Zip Code 21075		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) tank room clerk			16b. Kind of Business/Industry distillery	
17. Father's Name (First, Middle, Last) Zebulun Boggs				18. Mother's Name (First, Middle, Maiden Surname) Daisy				
19a. Informant's Name/Relationship (Type, Print) Virginia H. Boggs - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6333 Beechfield Avenue, Elkridge, Maryland 21075				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park			20c. Location - City or Town, State 3/20/00 Elkridge, Maryland		20d. Location - City or Town, State 4107 Wilkens Avenue Baltimore, Maryland 21229	
21. Signature of Funeral Service Licensee Ann Y. Zink				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EDEMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death ONE MONTH
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Styke m.s.		29c. License number P 09758		29d. Date signed (Month, Day, Year) 03, 17, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUZANNE SYSKO, MD 22 SOUTH GREENE ST. BALTIMORE MD 21201								
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

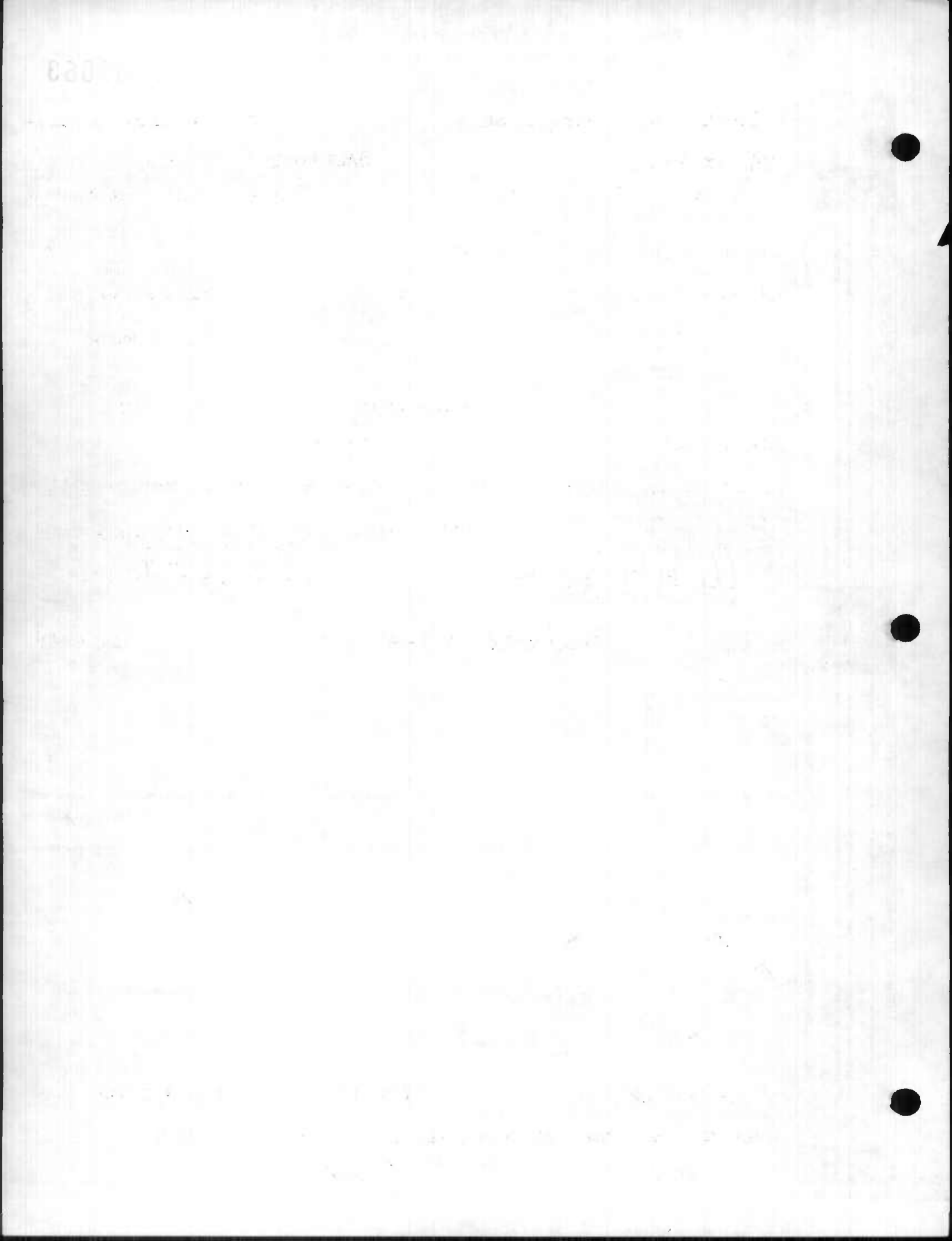
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09064

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GENEVIEVE M. BROWN				2. Date of Death Month 03 Day 16 Year 2000		3. Time of Death 12:55		
	4a. Facility Name (If not institution, give street and number) SAINT AGNES HEALTHCARE				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a		
Funeral Director	5. Social Security Number 212-22-3781		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 25, 1927	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 134 Garden Ridge Road				10f. Zip Code 21228		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) clerical worker		16b. Kind of Business/Industry glass			
17. Father's Name (First, Middle, Last) Carroll Tierney					18. Mother's Name (First, Middle, Maiden Summa) Catherine E. Ziegler				
19a. Informant's Name/Relationship (Type, Print) Albert E. Brown - husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Garden Ridge Road, Baltimore, Maryland 21228				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State 3/18/00 Baltimore, Maryland				
21. Signature of Funeral Service Licensee Ann Y. Zink					22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): RIGHT LOWER EXTREMITY ISCHEMIA Due to (or as a consequence of): RIGHT ILLIAC AND FEMORAL ARTERY THROMBOEMBOLI Due to (or as a consequence of): BILATERAL PNEUMONIA								Approximate Interval Between Onset and Death 5 DAYS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MIDDM, HTN, HISTORY of SCHIZOPHRENIA STATUS POST VENTRAL HERNIA REPAIR 03/07/2000								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Dr. Taylor MD, SURGICAL RESIDENT		29c. License number AS 2438528-1186		29d. Date signed (Month, Day, Year) 03/16/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VYACHESLAV FUZAYLOV 900 CATON AVENUE, BALTIMORE 21229									
31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

NAME GENEVIEVE M. BROWN

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09065

Baltimore, Maryland 21215-0020
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ALBERTA LAURENDA BONDS				2. Date of Death Month Day Year MARCH 15, 2000		3. Time of Death 0806 AM	
4a. Facility Name (If not institution, give street and number) 1924 DRUID HILL AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 217-24-1701		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 19 1927	
9. Birthplace (State or Foreign Country) MARYLAND							
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 1924 DRUID HILL AVENUE				10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry PRIVATE	
17. Father's Name (First, Middle, Last) GUY LEE HAROLD				18. Mother's Name (First, Middle, Maiden Surname) LESLIE V. GASKIN			
19a. Informant's Name/Relationship (Type, Print) Rosie Harold/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1924 Druid Hill Avenue, Baltimore, MD., 21217			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATIONAL		Date 3-21-00		20c. Location - City or Town, State BALTIMORE, MARYLAND	
21. Signature of Funeral Service Licensee Charles H. Powell				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24a. Was an autopsy performed? inspection 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Theodore M. Keig				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 17, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. Keig 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature Beverly B. Sparks			

State
Registrar

601

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09066

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Clifford Bosley

2. Date of Death

March

Day Year
16, 2000

3. Time of Death

8:45pm

4a. Facility Name (If not institution, give street and number)

214 Thistle Road

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

232-60-3507

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 16, 1937

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

214 Thistle Road

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Bosley Electric

17. Father's Name (First, Middle, Last)

James Lawson Bosley

18. Mother's Name (First, Middle, Maiden Surname)

Helen (Flowers)

19a. Informant's Name/Relationship (Type, Print)

Joyce M. Briggs Bosley-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

214 Thistle Road, Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hagan Community Cemetery

Date

3/21/00

20c. Location - City or Town, State

Morgantown,
West Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33212

29d. Date signed (Month, Day, Year)

3/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernita C. Taylor MD 1113 N Rolling Rd Catonsville Md 21228

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09067

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph Carroll Behning

2. Date of Death

MAR 17 2000

3. Time of Death

1300

4a. Facility Name (If not institution, give street and number)

ST. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-36-2337

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12/03/1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

322 Chalfonte Drive

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5+ College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Comercial and Fine Artist

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Albert Behning Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Penn

19a. Informant's Name/Relationship (Type, Print)

Mary Behning- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 Chalfonte Drive

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

New Cathedral Cemetery

Date

03/20

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert J. Rodach

22. Name and Address of Facility

Sterling-Ashton-Schwab Funeral Home Inc.

736 Edmondson Avenue, Balto, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Ralph Behning M.D.

29c. License number

P13598

29d. Date signed (Month, Day, Year)

MARCH, 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE BALTIMORE MARYLAND

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitNAME Behning, Ralph
Division of Vital Records, P.O. Box 68760,

A74

1700

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09068

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry Blanding		2. Date of Death Month March Day 18 Year 2000		3. Time of Death 0525
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death
Funeral Director	5. Social Security Number 212 46 7044	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) October 13, 1947		9. Birthplace (State or Foreign Country) Md		
Usual Residence of Decedent					
10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 1100 N. Bolton Street			10f. Zip Code 21201		10g. Citizen of What Country? U S A
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry Housing Authority
17. Father's Name (First, Middle, Last) Charlie Blanding			18. Mother's Name (First, Middle, Maiden Surname) Luenet Roberts		
19a. Informant's Name/Relationship (Type, Print) Luesta Owens - Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1522 Penrose Avenue Baltimore, Md 21223		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		20c. Location - City or Town, State 3-23-00 Baltimore, Md	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Klebsiella Pneumonia			Approximate Interval Between Onset and Death 3 days
		Due to (or as a consequence of):			
		b. Esophageal Cancer			4 months
		Due to (or as a consequence of):			
		c.			
		Due to (or as a consequence of):			
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier -mo . Intern		29c. License number RES-000		29d. Date signed (Month, Day, Year) March 18, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hunter C. Champion, mo 600 N Wolfe Street Baltimore, Maryland 21205					
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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CERTIFICATE #

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State of Maryland / Department of Health and Mental Hygiene **00 09070**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald M. Berends, Jr.					2. Date of Death Month MARCH Day 13 , 2000 Year		3. Time of Death 12:47 P.M.		
	4a. Facility Name (If not institution, give street and number) 512 SAVAGE STREET					4b. City, Town, or Location of Death BALTIMORE		4c. County of Death		
Funeral Director	5. Social Security Number 217-80-6688		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09-02-1959		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 512 Savage Street					10f. Zip Code 21224		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician			16b. Kind of Business/Industry Service Station			
17. Father's Name (First, Middle, Last) Ronald M. Berends, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Amelia Jane Burlock					
19a. Informant's Name/Relationship (Type, Print) Milford L. Berends					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Tolna Street, Baltimore, MD 21224					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus			Date 3-20-00		20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee <i>Charles Kaczorowski</i>					22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Asphyxia due to Hanging</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Found 3/13/00		28b. Time of Injury 1200 AM	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>subject engaged in outaerotic activity</i>		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) basement					28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, Maryland				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Therese M. King</i>					29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 14, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAR 21 2000					32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 09071

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Bristol Jr.					2. Date of Death Month Day Year March 15, 2000		3. Time of Death 5:30p.m.		
	4a. Facility Name (If not institution, give street and number) 2001 Poplar Grove Street					4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a		
Funeral Director	5. Social Security Number 219-28-3496		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 30, 1932		9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent									
10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 2001 Poplar Grove Street					10f. Zip Code 21216		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) 8th Grade					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter			16b. Kind of Business/Industry Bethlehem Steel		
17. Father's Name (First, Middle, Last) William Bristol, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Brown					
19a. Informant's Name/Relationship (Type, Print) Donald Bristol son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1806 E. Belvedere Avenue Baltimore, Md. 21239					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forrest Veterans March		Date 21		20c. Location - City or Town, State Owings Mills, Md.			
21. Signature of Funeral Service Licensee Herbert E. Nutter					22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Hypertensive Heart Disease</u> Due to (or as a consequence of): b. <u>Renal Insufficiency</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic UTI</u>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Joseph H. Manner					29c. License number D23646		29d. Date signed (Month, Day, Year) 3/20/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1232 Race Rd Balto, Md 21237										
31. Date filed (Month, Day, Year) MAR 21 2000			32. Registrar's Signature Benjamin B. Sparks							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 00 09072

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gary J. Beemer						2. Date of Death Month Day Year March 12, 2000		3. Time of Death 12:22 AM	
	4a. Facility Name (If not institution, give street and number) Harbor Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220 88 3752		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 24 Yrs.		8. Date of Birth (Month, Day, Year) July 2, 1975		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 100 East 11th Avenue				10f. Zip Code 21225		10g. Citizen of What Country? U.S.				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mason			16b. Kind of Business/Industry General Contracting			
17. Father's Name (First, Middle, Last) James Clifford Beemer						18. Mother's Name (First, Middle, Maiden Surname) Edra Ellen Bartlett				
19a. Informant's Name/Relationship (Type, Print) James Beemer / Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 East 11th Avenue Baltimore, Maryland 21225						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 3/16/00		20c. Location - City or Town, State Towson, Maryland		
21. Signature of Funeral Service Licensee <i>Donna M. Ziminski</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple gunshot wounds Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 3-11-2000		28b. Time of Injury 2340 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was shot by police		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Outside of Pizza Hut				28f. Location (Street and Number or Rural Route Number, City or Town, State) 5000 BIK Ritchie Hw Anne Arundel county, Maryland				
29b. Signature and title of certifier <i>Stephen Radentz, M.D.</i>				29c. License number OCME		29d. Date signed (Month, Day, Year) March 12, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature <i>Benita B. Sparks</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09073

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

OTIS P. Childers

2. Date of Death

March 18 2000

3. Time of Death

0655

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

401-22-8129

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 30, 1924

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6030 Moorehead Road

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Management

16b. Kind of Business/Industry

Social Security

Administration

17. Father's Name (First, Middle, Last)

Otis Pierce Childers, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary (Sallee)

19a. Informant's Name/Relationship (Type, Print)

Agnes Childers (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6030 Moorehead Road, Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crestlawn Memorial Park

Date

3/21/00

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

R. C. Witzke

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. INTRA ABDOMINAL INFECTION

Due to (or as a consequence of):

DAYS

c. CARDIO VASCULAR DISEASE

Due to (or as a consequence of):

YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. C. Witzke MD

29c. License number

P 116 99

29d. Date signed (Month, Day, Year)

MARCH - 18 - 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAULINO LUCIA

900 CATON AVE

BALTIMORE

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09074

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sophia</i>				2. Date of Death Month <i>MARCH</i> Day <i>14</i> Year <i>2000</i>				3. Time of Death <i>7:29 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death		
Funeral Director	5. Social Security Number <i>215-01-7210</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>84</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>09-17-1915</i>		9. Birthplace (State or Foreign Country) <i>MD</i>		
	Usual Residence of Decedent				10c. City, Town or Location				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10a. State <i>MD</i>		10b. County <i>n/a</i>		10e. Street and Number <i>516 S. Durham Street</i>				10f. Zip Code <i>21231</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>				16b. Kind of Business/Industry <i>Home</i>			
17. Father's Name (First, Middle, Last) <i>Stanislaus Chetnik</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Valerie Kuczynski</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Linda Pasquariello</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>516 S. Durham Street, Baltimore, MD 21231</i>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holy Rosary</i>		20c. Location - City or Town, State <i>3-17-00 Baltimore, MD</i>					
21. Signature of Funeral Service Licensee <i>Kaczorowski</i>				22. Name and Address of Facility <i>Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222</i>							
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. GASTROINTESTINAL BLEED</i> Due to (or as a consequence of): <i>b. ANASARCA</i> Due to (or as a consequence of): <i>c. RESPIRATORY FAILURE</i> Due to (or as a consequence of): <i>d.</i>											Approximate Interval Between Onset and Death <i>Two months</i> <i>Two weeks</i> <i>Three days</i>
Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>PULMONARY HYPERTENSION, HYPERTENSION, COLITIS</i>											23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Matthew Clues</i>				29c. License number <i>KES-000</i>		29d. Date signed (Month, Day, Year) <i>MARCH 14, 2000</i>	
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <i>MATTHEW CLUES MD, Johns Hopkins Bayview Medical Center Baltimore, MD 21224</i>											
31. Date filed (Month, Day, Year) <i>MAR 21 2000</i>				32. Registrar's Signature <i>P. Sparks</i>							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09075

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Bernard N. Cooper</i>				2. Date of Death Month <i>March</i> Day <i>19</i> Year <i>2000</i>				3. Time of Death <i>515pm</i>		
	4a. Facility Name (If not institution, give street and number) <i>Maryland General Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore City</i>				4c. County of Death <i>N/A</i>		
Funeral Director	5. Social Security Number <i>215-07-8436</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>80</i> Yrs.		8. Date of Birth Month <i>June</i> Day <i>30</i> Year <i>1919</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	Usual Residence of Decedent				10a. State <i>MD</i>				10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <i>481 Oxford Ct.</i>				10f. Zip Code <i>21217</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>laborer</i>				16b. Kind of Business/Industry <i>landscaping</i>			
17. Father's Name (First, Middle, Last) <i>Walter Hooper</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Emma Cooper</i>							
19a. Informant's Name/Relationship (Type, Print) <i>Yvonne McMillan - Francis Cates</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6748 Brookmont Dr. Balto. Md. 21207</i>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>London Park Cem</i>				Date <i>3-24-2000</i>		20c. Location - City or Town, State <i>Balto. Md.</i>	
21. Signature of Funeral Service Licensee <i>Carlton D. Dwyer</i>				22. Name and Address of Facility <i>Douglas Funeral Serv. Co. 1001 McCulloch St. Balto. Md. 21217</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Pneumonia</i> <i>Sepsis</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>M. Soumei, MD</i>				29c. License number <i>89357</i>				29d. Date signed (Month, Day, Year) <i>3/19/2000</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Maryam Soumei, M.D. 60 Maryland General Hospital</i>											
31. Date filed (Month, Day, Year) <i>MAR 21 2000</i>				32. Registrar's Signature <i>B. Sparks</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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10/10/1914

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State of Maryland / Department of Health and Mental Hygiene 00 09076

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD DOTSON				2. Date of Death Month Day Year MARCH 18 2000		3. Time of Death 0404										
	4a. Facility Name (If not institution, give street and number) ST AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death										
Funeral Director	5. Social Security Number 213-36-6605		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) 12-28-35										
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) BALTIMORE		10a. State MD		10b. County N/A										
To Be Completed by Funeral Director	10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3716 WOODRIDGE RD										
	10f. Zip Code 21229				10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LONGSHOREMAN		16b. Kind of Business/Industry MARTITINE										
	17. Father's Name (First, Middle, Last) VANDERBELT DOTSON				18. Mother's Name (First, Middle, Maiden Surname) MARY GARNETT												
	19a. Informant's Name/Relationship (Type, Print) RICHARD DOTSON, SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 WOODRIDGE RD, BALTIMORE, MD 21229												
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT ZION CEMETERY		20c. Location - City or Town, State 03-23-00 BALTIMORE										
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO, MD 21207												
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td rowspan="4"> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <i>Acute Myocardial Infarction</i></td> <td>Approximate Interval Between Onset and Death 1 hour</td> </tr> <tr> <td>b. <i>Diabetes</i></td> <td>years</td> </tr> <tr> <td>c. <i>Hypertension</i></td> <td>years</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>Acute Myocardial Infarction</i>	Approximate Interval Between Onset and Death 1 hour	b. <i>Diabetes</i>	years	c. <i>Hypertension</i>	years	d.
Immediate Cause (Final disease or condition resulting in death)	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>Acute Myocardial Infarction</i>	Approximate Interval Between Onset and Death 1 hour														
		b. <i>Diabetes</i>	years														
		c. <i>Hypertension</i>	years														
		d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <i>Kevin H. Schuchman MD</i>				29c. License number D38543		29d. Date signed (Month, Day, Year) March 18, 2000											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin H. Schuchman MD 900 Canton Avenue Baltimore, Maryland 21229																	
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature <i>G. Sparks</i>															

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09077

AMENDED ITEM #18 PER FH G781 3/21/2000 AH

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nicholas Diamantidis

2. Date of Death
Month Day Year

3 16 2000

3. Time of Death

1:40 AM

4a. Facility Name (If not institution, give street and number)

907 Regina Dr.

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

120-38-7122

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10/04/1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

907 Regina Drive

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Restaurateur

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

George Diamantidis

18. Mother's Name (First, Middle, Maiden Surname)

Eleni (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

Nicholas Diamantidis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

907 Regina Drive Baltimore, MD. 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greek Orthodox Cemetery

Date

03/18

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling Ashton Schwab Funeral Home, Inc.

736 Edmondson Ave. Baltimore, MD. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Gangrene @ leg

b.

Diabetic Mellitus type II

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Comp for heart failure

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-04971

29d. Date signed (Month, Day, Year)

3/16/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miguel A Heredia, MD - 413 COMMONWEALTH AVE BALTO, MD 21228

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

3

NICHOLAS DIAMANTIDIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09078

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHARON TAYLOR DENTON

2. Date of Death

Month Day Year
MARCH 20, 2000

3. Time of Death

0241

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

214-64-9142

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11/01/1952

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

221 NORTH BEAUMONT AVENUE

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WALTER L. TAYLOR

18. Mother's Name (First, Middle, Maiden Surname)

ALTA V. (VANGILDER)

19a. Informant's Name/Relationship (Type, Print)

JOHN DENTON (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

221 N. BEAUMONT AVE CATONSVILLE, MD 21228

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BALTO. WASH. CREMATORY

Date

3/21/00

20c. Location - City or Town, State

LAUREL, MD

21. Signature of Funeral Service Licensee

R. Chas. Witke

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.

1630 EDMONDSON AVE CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. MASSIVE HEMOPTYSIS

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

30 minutes

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that Initiated events
resulting in death) Last

b. NON SMALL CELL CANCER OF LUNG

Due to (or as a consequence of):

6 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☒ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jerome I. Snyder, M.D.

29c. License number

D22648

29d. Date signed (Month, Day, Year)

MARCH 20, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JEROME I. SNYDER, M.D. 900 SOUTH PATON AVENUE BALTIMORE MARYLAND 21229

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitDENTON, SHARON
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09079

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marsha Rose Deaver				2. Date of Death Month Day Year March 15, 2000				3. Time of Death 4:15 PM	
	4a. Facility Name (If not institution, give street and number) 1104 Pericles Drive				4b. City, Town, or Location of Death Bel Air				4c. County of Death Harford	
Funeral Director	5. Social Security Number 212-40-3196		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 58 yrs.		8. Date of Birth (Month, Day, Year) Feb. 3, 1942		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10c. City, Town or Location Bel Air		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10e. Street and Number 1104 Pericles Drive				10f. Zip Code 21015	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Years College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Production Worker				16b. Kind of Business/Industry Manufacturing				17. Father's Name (First, Middle, Last) Arthur Brechbiel	
	18. Mother's Name (First, Middle, Maiden Surname) Rose Hubbard				19a. Informant's Name/Relationship (Type, Print) (Daughter) Mrs. Kelly A. Urbaniak				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Pericles Drive Bel Air, Maryland 21015	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		20c. Date 3/18/2000		20d. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Metastatic Lung Cancer</u> Due to (or as a consequence of):	
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 7 months				Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D19714		
29d. Date signed (Month, Day, Year) 3/16/00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL PURCELL JHBMCL 4940 EASTERN AVE BALTIMORE MD 21224				31. Date filed (Month, Day, Year) MAR 21 2000		
32. Registrar's Signature 				33. State Registrar				DHHM 16 Rev 6/95		

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 09080

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marian Dalfonso

2. Date of Death
Month Day Year
MARCH 11 20003. Time of Death
0450

4a. Facility Name (If not Institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

189 16 0196

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

2/13/23

9. Birthplace (State or Foreign Country)

Phila. PA

Usual Residence of Decedent

10a. State

MD

10b. County

CECIL

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3893 Blue Ball Road

10f. Zip Code

21921

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Charles Joynes

18. Mother's Name (First, Middle, Maiden Surname)

Joanna Gwynne

19a. Informant's Name/Relationship (Type, Print)

Francis D'Alfonso

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3893 Blue Ball Rd. Elkton MD 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Calvary Cem.

Data

3/16/00

20c. Location - City or Town, State

Conshohocken PA

21. Signature of Funeral Service Licensee

E F Lassahn

22. Name and Address of Facility

E F Lassahn Funeral Home 11750 Belair Rd
Kingsville, MD 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Staph. aureus bilateral pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Urosepsis

Due to (or as a consequence of):

6 days

c. Acute Renal Failure

Due to (or as a consequence of):

6 days

d. septic shock syndrome

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

sick euthyroid syndrome

aortic stenosis

severe rheumatoid arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christie E.K. Horah, D.O.

29c. License number

H0054380

29d. Date signed (Month, Day, Year)

03/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christie E.K. Horah, D.O. 412 Suburban Plaza, Newark, DE 19711

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09081

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eileen Elizabeth Dye				2. Date of Death Month Day Year MARCH 16 2000		3. Time of Death 10:05 PM	
	4e. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 213 28 7867		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) May 9, 1931	
	9. Birthplace (State or Foreign Country) Maryland		10a. Street and Number 8017 Stone Haven Drive		10f. Zip Code 21060		10g. Citizen of What Country? U.S.	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipping Clerk		16b. Kind of Business/Industry Warehousing			
	17. Father's Name (First, Middle, Last) Lorenzo Ambrose				18. Mother's Name (First, Middle, Maiden Surname) Anna Gothe			
	19a. Informant's Name/Relationship (Type, Print) Thomas Dye Jr. / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8017 Stone Haven Drive Glen Burnie, Md. 21060			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 3/20/00		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee <i>Donna M. Zmijewski</i>		22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Septic Shock</i> Due to (or as a consequence of): b. <i>Perforated pre-pyloric ulcer</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Pancreatitis</i> <i>Cholelithiasis</i> <i>Cardiomyopathy</i>							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Kevin Doyle</i>		29c. License number D31122		29d. Date signed (Month, Day, Year) 3/17/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kevin Doyle, 203 Hospital Drive, #206, Glen Burnie, MD 21061</i>							
	31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature <i>Barbara B. Sparks</i>					
	State Registrar							

ORIGINAL

WORTHINGTON
FROM 1910 TO 1915

1910-1915



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09082

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Virginia Daugherty				2. Date of Death Month Day Year March 17 2000		3. Time of Death 3:05AM	
	4a. Facility Name (If not institution, give street and number) 1012 Leeds Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-14-6707		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 28, 1920	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1012 Leeds Avenue		10f. Zip Code 21229		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) John William Chaires				18. Mother's Name (First, Middle, Maiden Surname) Bertha McNamee				
19a. Informant's Name/Relationship (Type, Print) Marie Louise Daugherty (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2035 Sherlock Holmes St. Eldersburg, MD 21784				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Memorial Park		20c. Location - City or Town, State 3/21/00 Easton, Maryland				
21. Signature of Funeral Service Licensee Shannon McNamee				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Patrick W. White MD		29c. License number D23365		29d. Date signed (Month, Day, Year) 3/20/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick W. White 716 Marden Chase Lane #205, Baltimore, MD								
31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature B. Sparks						

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09083

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Brian H. Eubanks Jr.				2. Date of Death Month Day Year MARCH 17, 2000		3. Time of Death 15:35 PM	
	4a. Facility Name (If not institution, give street and number) 1630 NORTH MONTFORD AVE.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-13-4496		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 14 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 12, 1985	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2125 E. Federal St.		10f. Zip Code 21213		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Afro American		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry School				
17. Father's Name (First, Middle, Last) Brian H. Eubanks Sr.				18. Mother's Name (First, Middle, Maiden Surname) Lavern D. Murphy				
19a. Informant's Name/Relationship (Type, Print) (aunt) Ms. Meg Owens				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 Braddish Ave. 1st Floor Balto. Md. 21216				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. park		20c. Date 3/24/2000		20d. Location - City or Town, State Balto. Co. Md.		
21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONTACT GUNSHOT WOUND TO HEAD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 3/17/00		28b. Time of Injury 3:20 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) SCENE		28d. Describe how injury occurred SELF-INFLICTED GUNSHOT WOUND		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1630 NORTH MONTFORD AVE. BALTIMORE, MD				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J.M. T...						
29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 18, 2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TIRUS, M.D.		111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature Beverly B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09084

Certificate of Death

Reg. No.

AMENDED ITEM #8 PER FH G781 3/21/2000 AH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SOPHIA LOUISE FREEMAN				2. Date of Death Month Day Year MARCH 16 2000		3. Time of Death 4:30AM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-34-2507		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth Month Day Year APRIL 4, 1913	
	9. Birthplace (State or Foreign Country) NEW YORK		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 725 MT. WILSON LANE APT. 404		10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PERSONNEL SUPERINTENDENT		16b. Kind of Business/Industry HUTZLER BROTHERS			
	17. Father's Name (First, Middle, Last) MORRIS FLOCKS				18. Mother's Name (First, Middle, Maiden Surname) ROSE BLACKMAN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MARTIN FREEMAN/SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9064 FALLS CREEK MAIN DURANGO, COLORADO 81301			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW		20c. Location - City or Town, State 3/19/2000 REISTERSTOWN, MD.		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal Insufficiency Due to (or as a consequence of): b. Myocardial Infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 month 3 months			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number D 45708		29d. Date signed (Month, Day, Year) March 16, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY J. KERKVLIT MD. 2435 W. Belvedere, Baltimore, MD 21215							
State Registrar	31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09085

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BLANCHE R. GRAY

2. Date of Death
Month Day Year

MARCH 20 2000

3. Time of Death

11:45 AM

4a. Facility Name (If not institution, give street and number)

FUTURE CARE NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

110-18-0167

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

FEB. 07, 1922

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3325 ESSEX ROAD

10f. Zip Code

21207

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BEAUTICIAN

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

ROMMIE

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

LOAD HOLT

19a. Informant's Name/Relationship (Type, Print)

CHERYL CHARLES (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3325 ESSEX ROAD, BALTIMORE, MD. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

3-24-00

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTO, MD. 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive cardiomyopathy
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Insulin dependent

Ventricular arrhythmias

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D25112

29d. Date signed (Month, Day, Year)

3/21/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAHOORA KAWAJA 1777 Reisterstown Rd, #108 Baltimore MD 21208

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

[Signature]

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BLANCHE R. GRAY
Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09086

Amended Item#20b per FHG781 3/22/2000 EW Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michael Joseph Goshaney

2. Date of Death

March 19, 2000

3. Time of Death

7:10PM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore Co.

Funeral
Director

5. Social Security Number

186-01-4846

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 14, 1918

9. Birthplace (State or Foreign Country)

New Boston, PA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Sparks

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13945 York Road

10f. Zip Code

21152-9666

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No W.W.II
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Material Analyst

16b. Kind of Business/Industry

Glenn L. Martin

17. Father's Name (First, Middle, Last)

Michael Joseph Goshaney, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Maria Elizabeth Hrametz

19a. Informant's Name/Relationship (Type, Print) (Wife)

Mrs. Helen Theresa Goshaney (nee Ross)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13945 York Road Sparks, Maryland 21152-9666

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens 3/19/2000 Timonium, Maryland

Date

23

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Parkinson's disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

multi-system atrophy (Shy-Drager Syndrome)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W.A. Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

March 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley / GBMC 6201 N. Charles St. Balto. Md

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. Sparks

21 2000

State Registrar

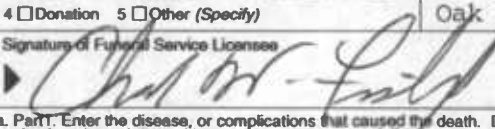
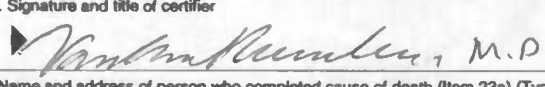

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09087



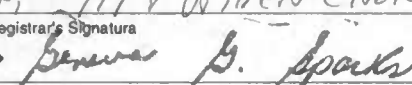
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LENA GAVEL				2. Date of Death Month Day Year MARCH 17 2000				3. Time of Death 4:28 a.m.			
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A			
Funeral Director	5. Social Security Number 220-18-9002		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 19, 1917		9. Birthplace (State or Foreign Country) West Virginia			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 7 Northship Road				10f. Zip Code 21222		10g. Citizen of What Country? United States					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (14 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder				16b. Kind of Business/Industry Steel Industry					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John R. Calebaugh				18. Mother's Name (First, Middle, Maiden Surname) Chessie A. Whitecotton							
	19a. Informant's Name/Relationship (Type, Print) Dolores Noell/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Northship Road Dundalk, Maryland 21222							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 3/20/2000		20c. Location - City or Town, State Baltimore, Maryland					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)		a. ISCHEMIC CARDIOMYOPATHY / CONGESTIVE HEART FAILURE Due to (or as a consequence of):									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. ACUTE ON CHRONIC RENAL FAILURE Due to (or as a consequence of):									
			c. PULMONARY EDEMA Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
DIABETES MELLITIS												
HYPERTENSION												
CORONARY ARTERY DISEASE												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  M.D.				29c. License number 20306		29d. Date signed (Month, Day, Year) MARCH 17, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VANDANA RAMULU, M.D. 4940 EASTERN AVENUE, BALTIMORE, MARYLAND												
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature 										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09088

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH LATHAM GILSTRAP						2. Date of Death Month Day Year MARCH 18 2000		3. Time of Death 1:05AM						
	4a. Facility Name (If not institution, give street and number) CHARLESTOWN				4b. City, Town, or Location of Death CATONSVILLE		4c. County of Death BALTIMORE								
Funeral Director	5. Social Security Number 212-32-0921		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 10/23/1915		9. Birthplace (State or Foreign Country) SOUTH CAROLINA						
	Usual Residence of Decedent														
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 713 MAIDEN CHOICE LANE				10f. Zip Code 21228		10g. Citizen of What Country? USA									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4YRS				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMN. BALTO. HOUSING AUTH. AUTHORITY			16b. Kind of Business/Industry BALTIMORE HOUSING								
17. Father's Name (First, Middle, Last) VICTOR LATHAM						18. Mother's Name (First, Middle, Maiden Surname) MARY WILLIAMS									
19a. Informant's Name/Relationship (Type, Print) JAMES R.L. GILSTRAP (SON)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 FARRINGTON DR. GREENVILLE, S.C. 29615.									
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY		20c. Date 03/20/2000		20d. Location - City or Town, State BALTO., MD.							
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death YEARS					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number D44748		29d. Date signed (Month, Day, Year) MARCH 18, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW J. NORLETT 711 MAIDEN CHOICE LANE CATONSVILLE, MD															
31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature 											

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09089

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KIMBERLY MONIQUE GODWIN-BARTO

2. Date of Death

MARCH 19 2000

Day

Year

3. Time of Death

752 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-82-2376

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 25, 1961

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

512 Adobe Road

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

C

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telecommunication

16b. Kind of Business/Industry

FBI

17. Father's Name (First, Middle, Last)

EPHRAIM H. HARVARD

18. Mother's Name (First, Middle, Maiden Surname)

ROCHELLE GODWIN

19a. Informant's Name/Relationship (Type, Print)

ROCHELLE GODWIN Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2607 Allendale Rd Baltimore MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cem.

Date

3/24/00 Glen Burnie, MD

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Albert P. Givie Funeral Hm PA
638 N. Guilford St. Baltimore MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D11171

29d. Date signed (Month, Day, Year)

MARCH 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.P. WILLIAMSON II 405 FREDERICK ROAD CATONSVILLE MARYLAND 21228

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09090

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edwin Gudley					2. Date of Death Month Day Year March 17 2000			3. Time of Death 8:15 P.M.	
	4a. Facility Name (If not institution, give street and number) Locust Lodge					4b. City, Town, or Location of Death Pasadena			4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220 03 4732		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 8, 1915		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Pasadena				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 184 Meadow Road					10f. Zip Code 21122			10g. Citizen of What Country? U.S.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W. II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Bethlehem Steel		
17. Father's Name (First, Middle, Last) unknown					18. Mother's Name (First, Middle, Maiden Surname) unknown					
19a. Informant's Name/Relationship (Type, Print) Dolores Rocklin					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 184 Meadow Road Pasadena, Maryland 21122					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Balto. National Cemetery			20c. Date 3/21/00		20d. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee <i>Donna M. Zimierowski</i>					22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Upper Airway Obstruction and Respiratory Failure</i> Due to (or as a consequence of): b. <i>Vocal cord Paralysis and Edema</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 wks	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GERD Dysphagia Dementia								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Home							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>David A. Schwartz</i>			29c. License number 417744		29d. Date signed (Month, Day, Year) 3/23/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID A. SCHWARTZ 300 Hospital Drive, Glen Burnie, Md. 21061										
31. Date filed (Month, Day, Year) MAR 21 2000			32. Registrar's Signature <i>Benjamin B. Sparks</i>							

ORIGINAL

00 09091

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09092

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RAYMOND JENNINGS HELVIG				2. Date of Death Month Day Year MARCH 14, 2000		3. Time of Death 14:53 PM	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 485-07-9153		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) MAY 14, 1915	
	9. Birthplace (State or Foreign Country) IOWA		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE	
Usual Residence of Decedent								
10e. Street and Number 715 MAIDEN CHOICE LANE CR417			10f. Zip Code 21228			10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWI			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: WHITE			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 +			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) VETERINARY RESEARCH SUPERVISOR NIH		
16. Kind of Business/Industry			17. Father's Name (First, Middle, Last) HANS HELVIG			18. Mother's Name (First, Middle, Maiden Surname) AMALIA (MYRLAND)		
19a. Informant's Name/Relationship (Type, Print) ELIZABETH HELVIG (WIFE)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 MAIDEN CHOICE LANE BALTO., MD 21228					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) OAKLAWN CEMETERY			20c. Location - City or Town, State 3/21/00 NORTHFIELD, MN		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LEUKEMIC INFILTRATE OF LUNGS Due to (or as a consequence of): b. ACUTE TRANSFORMATION OF CHRONIC Due to (or as a consequence of): c. MYELOMONOCYTIC LEUKEMIA Due to (or as a consequence of): d.			Approximate Interval Between Onset and Death DAYS DAYS					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 			29c. License number DO9990			29d. Date signed (Month, Day, Year) MARCH 15, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MICHAEL E. PELCZAR M.D. ST. AGNES HEALTHCARE								
31. Date filed (Month, Day, Year) MAR 21 2000			32. Registrar's Signature  900 CATON AVE 21229					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09093

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elnor E. Hopwood				2. Date of Death Month Day Year March 18, 2000		3. Time of Death 7:30am	
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-18-6206		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) 7/6/22	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location RIDGELEIGH	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1840 DARRICH DRIVE		10f. Zip Code 21234		
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) 6TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER-OWNER		16b. Kind of Business/Industry SERVICE STATION		
17. Father's Name (First, Middle, Last) HOWARD W. HOPWOOD				18. Mother's Name (First, Middle, Maiden Surname) MAY HOFFMAN				
19a. Informant's Name/Relationship (Type, Print) AUDREY HOPWOOD WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1840 DARRICH DRIVE BALTIMORE, MD 21234				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. OLIVET CEMETERY		20c. Date 3/22/2000		20d. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) a. Multisystem organ failure Due to (or as a consequence of): b. Sepsis - unknown cause. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 3/14/00 3/12/00								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Alvin A. Phillips MD				29c. License number D42599		29d. Date signed (Month, Day, Year) 3/18/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Constan Phillips, MD 8028 Retenue Hwy Pasadena, MO 2122								
31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature Gene B. Spahr				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09094

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Vina Hollar

2. Date of Death

March 14 2000

3. Time of Death

11:55 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

KESWICK NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

212-22-8296

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4/12/06

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8519 LOCH RAVEN BLVD.

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

CHARLES LOAN

18. Mother's Name (First, Middle, Maiden Surname)

MARY MARGARET AYERS

19a. Informant's Name/Relationship (Type, Print)

EVELYN H. JOHNSON DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8519 LOCH RAVEN BLVD. TOWSON, MD 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

DULANEY VALLEY MEM. GAR. 3/17/2000 COCKEYSVILLE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Advanced dementia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

15 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Isabelle MacGregor MD

29c. License number

D13657

29d. Date signed (Month, Day, Year)

March, 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Isabelle MacGregor, KESWICK, 700 W. 40th STREET BALTIMORE, MD 21211

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-0000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09095

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Julia S. Harrison						2. Date of Death Month Day Year MARCH 19 TH 2000		3. Time of Death 0837		
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-30-6883		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 12-15-1915		9. Birthplace (State or Foreign Country) Indiana		
	Usual Residence of Decedent										
10a. State Md		10b. County Baltimore		10c. City, Town or Location Pikesville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1200 Cobb Road				10f. Zip Code 21208		10g. Citizen of What Country? U S A					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 2 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse Minister			16b. Kind of Business/Industry University				
17. Father's Name (First, Middle, Last) John L. Saunders						18. Mother's Name (First, Middle, Maiden Surname) Margaret Moore					
19a. Informant's Name/Relationship (Type, Print) Robert Harrison- Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Cobb Road Pikesville, Md 21208					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Md National Memorial Pk			20c. Location - City or Town, State 3-23-00 Laurel, Md					
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adult Respiratory Distress Syndrome Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i> MD						29c. License number 000 RES		29d. Date signed (Month, Day, Year) March 19 TH 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Meister Sinai Hospital of Baltimore											
31. Date filed (Month, Day, Year) MAR 21 2000			32. Registrar's Signature <i>[Signature]</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09096

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grover Wood Hamilton				2. Date of Death Month Day Year March 14, 2000		3. Time of Death 11:45AM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center For Hospice Care				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-18-5035		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) August 7, 1917	
	9. Birthplace (State or Foreign Country) Harford Co. Maryland		10a. State Maryland		10b. County Harford		10c. City, Town or Location BelAir	
To Be Completed by Funeral Director	10a. Street and Number 2462 Thomas Run Road		10f. Zip Code 21015		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Musician & Music Teacher		16b. Kind of Business/Industry Music Industry			
	17. Father's Name (First, Middle, Last) Grover Harrison Hamilton		18. Mother's Name (First, Middle, Maiden Surname) Rose Ella Durham		19a. Informant's Name/Relationship (Type, Print) Mrs. Kathryn D. Hamilton (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2462 Thomas Run Road BelAir, MD. 21015	
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro/Crematory		20c. Location - City or Town, State 3/17/2000 Baltimore, MD.		20d. Date	
	21. Signature of Funeral Service Licensee E. F. Lassahn		22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, MD. 21087		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. multiple myeloma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death one year	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
State Registrar	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier W.A. Riley, MD		29c. License number 025205		29d. Date signed (Month, Day, Year) March 14, 2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley, MD 6701 N. Charles St. Balto. MD 21208		31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature B. Sparks			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

G782 7-00-00
Certificate of Death

Reg. No.

00 09097

JOHN HOBBS

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John T. Hobbs				2. Date of Death Month MARCH Day 14 Year 2000				3. Time of Death 12:18 PM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 219-14-1185	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 9, 1925		9. Birthplace (State or Foreign Country) Balto.MD.		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Kingsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 11714 Mohr Road				10f. Zip Code 21087		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ARMY If Yes, Give Year or Dates: 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) n/a				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Manager/Body Shop			16b. Kind of Business/Industry Automotive / Frankel Cadillac			
17. Father's Name (First, Middle, Last) Elmer Harry Hobbs				18. Mother's Name (First, Middle, Maiden Surname) Katherine A. Oliver						
19a. Informant's Name/Relationship (Type, Print) Joanne Rawl				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 N. Hickory Ave. Apt. #2 BelAir, MD. 21014						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Mausoleum				20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park		Date 3/17/2000		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE COMPLICATED BY MULTIPLE INJURIES										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 3-14-00		28b. Time of Injury 11:37 A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT FELL FROM LADDER		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) CAR DEALER SHOP				28f. Location (Street and Number or Rural Route Number, City or Town, State) 201 REISTERSTOWN, RD. PIKESVILLE, MARYLAND						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 15, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) APR 07 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09098

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances D. Hoffman						2. Date of Death Month March Day 15 Year 2000		3. Time of Death 0800				
	4a. Facility Name (If not institution, give street and number) Stella Maris at Mercy Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A				
Funeral Director	5. Social Security Number 213 09 9306		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) May 28, 1910		9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent						10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		
10e. Street and Number 4128 - 6th Street						10f. Zip Code 21225		10g. Citizen of What Country? U.S.		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+) 						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Clothing				
17. Father's Name (First, Middle, Last) Joseph Golebiewski						18. Mother's Name (First, Middle, Maiden Surname) Tillie Preykowski							
19a. Informant's Name/Relationship (Type, Print) Lee Bruce / Nephew						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8109 Armiger Drive Pasadena, Maryland 21122							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery			20c. Location - City or Town, State Baltimore, Maryland		20d. Date 3/17/00		
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Leukemia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):												Approximate Interval Between Onset and Death 6 weeks	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. metastatic Ovarian Carcinoma													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number 007930			29d. Date signed (Month, Day, Year) March 15, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marvin J. Feldman MD						301 St. Paul Place Baltimore, Md. 21202							
31. Date filed (Month, Day, Year) MAR 21 2000						32. Registrar's Signature <i>[Signature]</i>							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09099

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM Joseph HEITZER				2. Date of Death Month Day Year MARCH 15 2000		3. Time of Death 9:25 AM		
	4a. Facility Name (If not institution, give street and number) Harbor Hospital Center				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death		
Funeral Director	5. Social Security Number 220-14-8017		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 26, 1925	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1612 Inverness Ave.				10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operation		16b. Kind of Business/Industry Paper Production			
17. Father's Name (First, Middle, Last) Ellis Joseph Heitzer				18. Mother's Name (First, Middle, Maiden Surname) Sarah Warren					
19a. Informant's Name/Relationship (Type, Print) Gladys M. Heitzer, spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Inverness Ave. Baltimore, MD. 21230					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens		Data 03-18-00		20c. Location - City or Town, State Essex, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COLON CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death ONE MONTH									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier CC L MD				29c. License number D24076		29d. Date signed (Month, Day, Year) MARCH 15, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUNG CHU NG MD HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST. BALTIMORE, 21225									
31. Date filed (Month, Day, Year) MAR 21 2000			32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #5, 10E PER F.H. G781 3-21-2000 WR.

Certificate of Death

Reg. No.

00 09100

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Milton Jones				2. Date of Death Month: March Day: 19 Year: 2000				3. Time of Death 0524	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 411-28-7891		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 18, 1926		9. Birthplace (State or Foreign Country) N. CAROLINA	
	10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 6613 1600 W. MT. ROYAL AVE. APT. 1007				10f. Zip Code 21217		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 9 College (1-4 or 5+):		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Parking Lot Attendant				16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) HORACE JONES				18. Mother's Name (First, Middle, Maiden Surname) Cleo Tunston					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Yvonne C. Rice				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6613 Ridgeborne Dr. Balto. Md 21237					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State Balto. Md		20d. Date 3/24/2000			
	21. Signature of Funeral Service Licensee Glenn Adams		22. Name and Address of Facility MARSHALL W. JONES, JR. 12H.P.A. 4101 Edmondson Ave Balto. Md 21229							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Anoxic Brain Injury Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Matthew Hernandez MD				29c. License number P11614		29d. Date signed (Month, Day, Year) MARCH 19, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATHEW HERNANDEZ DEPT OF MEDICINE UNIVERSITY OF MARYLAND BALTIMORE, MD 21201										
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature Geneva B. Sparks								
State Registrar										

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09101

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MOZELLE

JONES

2. Date of Death

Month Day Year
MARCH 17 2000

3. Time of Death

03:08AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-34-9614

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 7, 1937

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2609 Grogan Street

10f. Zip Code

21213

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Baltimore City
Public Schools

17. Father's Name (First, Middle, Last)

Jacob Williams

18. Mother's Name (First, Middle, Maiden Surname)

Mozelle Phyllips

19a. Informant's Name/Relationship (Type, Print)

Angela Patterson-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 N. Patterson Park Ave Apt. 2 Baltimore, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Memorial Garden

Date

Mar 23
2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Calvin L. Williams

22. Name and Address of Facility

Smith & Williams Funeral Home, P.A.
2818 East Baltimore Street Baltimore, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EMBOLISM
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES, OBESITY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Friedewald, MD

29c. License number

RES-0000

29d. Date signed (Month, Day, Year)

MARCH 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN FRIEDELWALD 601 N. Caroline St. BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09102

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANTHONY J. JACKSON

2. Date of Death

Month

Day

3. Time of Death

March 17 2000 1:26p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Balto

4c. County of Death

N/A

5. Social Security Number

220-52-3770

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
7-19-1950

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

Balto

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2403 Battersea Place

10f. Zip Code

21244

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction Company

17. Father's Name (First, Middle, Last)

William P. Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Alice Washington

19a. Informant's Name/Relationship (Type, Print)

Alice Jackson - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2403 Battersea Place Balto, Md 21244 Apt 102

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest Veteran

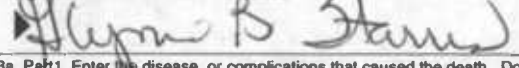
Date

3-23-00

20c. Location - City or Town, State

Owings Mills, Md

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

March F/H West

4300 Wabash Avenue

Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Septic Shock

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Pneumonia

Due to (or as a consequence of):

End stage renal disease

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending

Investigation

2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

89352

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dinesh Nagar C/O Maryland General Hospital

State
Registrar

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature



ORIGINAL

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09103.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ernest A. Johnson, Jr.				2. Date of Death Month Day Year Mar. 16, 2000				3. Time of Death 11:55am		
	4a. Facility Name (If not institution, give street and number) 112 S. Twin Circle Way				4b. City, Town, or Location of Death Baltimore				4c. County of Death NA		
Funeral Director	5. Social Security Number 216-52-2347		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) 05-30-49		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent										
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 112 S. Twin Circle Way				10f. Zip Code 21227				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (14 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver				16b. Kind of Business/Industry Silver Seas Inc.			
17. Father's Name (First, Middle, Last) Ernest A. Johnson, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Redmond							
19a. Informant's Name/Relationship (Type, Print) Diane Johnson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 S. Twin Circle Way Baltimore, MD 21227							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MT. Zion Cemetery			20c. Location - City or Town, State 03-21-2000 Lansdowne, MD					
21. Signature of Funeral Service Licensee Bladys Wames				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LIVER FAILURE Due to (or as a consequence of): b. cirrhosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier David L. Stewart				29c. License number D32273				29d. Date signed (Month, Day, Year) 3/20/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David L. Stewart 29 S PITCH St BALT 21201											
31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature Benita S. Spach							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09104

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Amelia Jones

2. Date of Death

Month
MARCH

Day

10

Year

2000

3. Time of Death

5:00PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

220-22-2996

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
04-29-28

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7828 Charlesmont Road

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (14 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Henry Goetzinger

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Baier

19a. Informant's Name/Relationship (Type, Print)

Mr. Charles Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7828 Charlesmont Rd., Baltimore, MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sacred Heart of Jesus

Date

3-14-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kaczorowski Funeral Home, P.A.
1201 Dundalk Avenue, Baltimore, MD 2122223a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 days

1 wk

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D54967

29d. Date signed (Month, Day, Year)

3/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huanrong Jiang 6701 N Charles St, Baltimore, MD 21204

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

State
RegistrarNAME: Jones, Amelia
MD CAT#

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09105

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SOPHIE KLEIN

2. Date of Death

March 16, 2000

3. Time of Death

6:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH WEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

218-62-0341

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

AUG. 31, 1906

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7920 SCOTTS LEVEL ROAD

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SIMON

18. Mother's Name (First, Middle, Maiden Surname)

SOLOWAY

JENNIE

COBLENTZ

19a. Informant's Name/Relationship (Type, Print)

STEVE KLEIN / GRANDSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11806 RIDGEMONT ROAD - LUTHERVILLE, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBREW YOUNG MEN CEMETERY 3/17/00 WOODLAWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

CHP
Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OBS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44J00

29d. Date signed (Month, Day, Year)

March 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

45 IMPERIAL, JR. - NWGte

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09106

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine S. Lowman

2. Date of Death
Month Day Year

march 18, 2000

3. Time of Death

4:00pm

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

219-30-5299

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 10, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1127 Scott Street

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

clerk

16b. Kind of Business/Industry

photo studio

17. Father's Name (First, Middle, Last)

Ruby M. Lowman

18. Mother's Name (First, Middle, Maiden Surname)

Sophie C. Smith

19a. Informant's Name/Relationship (Type, Print)

Mildred A. Davis - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1205 Scott Street, Baltimore, Maryland 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery

Date

3/22/00

20c. Location - City or Town, State

Brooklyn Park, Maryland

21. Signature of Funeral Service Licensee

Ann G. Zink

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue

Baltimore, Maryland

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. seizure
Due to (or as a consequence of):

b. CVA
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 minutes

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Rennert MD

29c. License number

96711

29d. Date signed (Month, Day, Year)

march 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jodi Rennert-Arlev

JHBMC, Eastern Ave, Balt-MD 21224

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09107

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

NATHANIEL O. Little SR.

2. Date of Death

March 17th 2000

3. Time of Death

12:10 AM

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-52-7427

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 18, 1949

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1915 Park Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shift Supervisor

16b. Kind of Business/Industry

Beverage Capital Co.

17. Father's Name (First, Middle, Last)

Nathaniel Little

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Bernice Nutt

19a. Informant's Name/Relationship (Type, Print) (wife)

Mrs. Georgianna Little

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2607 Robb St. Balto. Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem. Park

Date

3/23/2000

20c. Location - City or Town, State

Balto. Co. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

a. Due to (or as a consequence of):

End stage AIDS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Terence Lamb M.D.

29c. License number

D37223

29d. Date signed (Month, Day, Year)

March 17th 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terence Lamb, (8677) Bon Secours Hospital, Baltimore MD

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

Benjamin E. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09108

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) <i>Ernest Liggs</i>				2. Date of Death Month <i>03</i> Day <i>18</i> Year <i>2000</i>		3. Time of Death <i>11:30AM</i>	
4a. Facility Name (If not institution, give street and number) <i>Veteran's Administration Hospital, 10 N. Greene Street</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
5. Social Security Number <i>215-28-9595</i>		6. Sex <i>1 M 2 F</i>	7. Age (In yrs. last birthday) <i>75</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>1-23-1925</i>	9. Birthplace (State or Foreign Country) <i>Va.</i>
Usual Residence of Decedent							
10a. State <i>MD</i>		10b. County <i>U.S.A.</i>		10c. City, Town or Location <i>Balto.</i>		10d. Inside City Limits <i>1 Yes 2 No</i>	
10e. Street and Number <i>5220 YORK Rd.</i>				10f. Zip Code <i>21212</i>		10g. Citizen of What Country? <i>U.S.A</i>	
11. Marital Status <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>		12. Was Decedent Ever in U.S. Armed Forces? <i>1 Yes 2 No</i> <i>WW II</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 Yes 2 No</i> Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th Grade</i> College (1-4 or 5+) <i>N/A</i>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Old Jobs</i>		16b. Kind of Business/Industry <i>Labor</i>	
17. Father's Name (First, Middle, Last) <i>Unknown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Unknown</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Shelia Pinkney (daughter)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4221 Cressheights Rd. Balto. Md. 21215</i>			
20a. Method of Disposition <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GARRISON FOREST VA.</i>		Date <i>3-23-00</i>		20c. Location - City or Town, State <i>GARRISON FOREST</i>	
21. Signature of Funeral Service Licensee <i>Patricia Bates</i>				22. Name and Address of Facility <i>Bates Funeral Home 1129 N. Caroline St. Baltimore, Maryland 21213</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		e. <i>Sepsis</i>					Approximate Interval Between Onset and Death <i>10 days</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <i>Enterocutaneous Fistula</i>					<i>14 days</i>
		c. <i>Renal Failure</i>					<i>64 days</i>
		d. <i>Right Flank Incisional Hernia</i>					<i>66 days</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <i>1 Yes 2 No 3 Probably 4 Unknown</i>	
25. Was case referred to medical examiner? <i>1 Yes 2 No</i>		26. Place of Death (Check only one) Hospital: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> Other: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i>					
27. Manner of Death <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</i>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <i>1 Yes 2 No</i>	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
29e. Certifier (Check only one) <i>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>		29b. Signature and title of certifier <i>Physician</i>		29c. License number <i>AV4176435M12447</i>		29d. Date signed (Month, Day, Year) <i>3/18/2000</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Amir Moifar MD 10 N. Greene Street, Baltimore, MD</i>							
31. Date filed (Month, Day, Year) <i>MAR 21 2000</i>		32. Registrar's Signature <i>Benjamin B. Sparks</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09109

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Lambert

2. Date of Death

Month Day Year

March 13, 2000

3. Time of Death

8:50 AM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

266-62-2549

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/15/15

9. Birthplace (State or Foreign Country)

Monroe, Ala.

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

3276 Greenwich Court

10f. Zip Code

20602

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Henry Chamber

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Chamber

19a. Informant's Name/Relationship (Type, Print)

Annie R. McPhatten

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

/daughter 3276 Greenwich Ct., Waldorf, MD 20602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Andrew's Cemetery 3/18/00 Panama City, Fla.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John McPhatten
CO348

22. Name and Address of Facility

Latney's Funeral Home, Inc.

3831 Georgia Ave., NW, Wash., DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Encephalopathy

Due to (or as a consequence of):

1 month

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage Renal Disease

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

F. M. Griger MD

29c. License number

D-50350

29d. Date signed (Month, Day, Year)

3/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank L. Kriger, MD 7C Post Office Road, Waldorf, Maryland 20602

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202535.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Handwritten signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09110

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD B. LOCHTE, JR.

2. Date of Death

Month Day Year
MARCH 17, 2000

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

8210 RIDER AVENUE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

220-05-7774

6. Sex

XX ☐ M ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11-10-1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

8210 RIDER AVENUE

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YEARS

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

VICE PRESIDENT

16b. Kind of Business/Industry

ESSKAY MEAT
COMPANY

17. Father's Name (First, Middle, Last)

BERNARD B. LOCHTE, SR.

18. Mother's Name (First, Middle, Maiden Surname)

BARBARA KURDLE

19a. Informant's Name/Relationship (Type, Print)

BERNARD B. LOCHTE, III (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8210 RIDER AVENUE, TOWSON, MARYLAND, 21204

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

LORRAINE PARK CEM.

Date

3-20

20c. Location - City or Town, State

WOODLAWN, MD. 21207

21. Signature of Funeral Service Licensee

R. G. Ruth

22. Name and Address of Facility

HENRY W. JENKINS AND SONS COMPANY
4905 YORK ROAD, BALTIMORE, MARYLAND, 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Transitional Cell Carcinoma of the Ureter 2 years

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease 15 years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28e. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. G. Ruth

29c. License number

D33887

29d. Date signed (Month, Day, Year)

March 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT J. VISSING, M.D., 4300 N. CHARLES ST., BALTO., MD., 21218

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

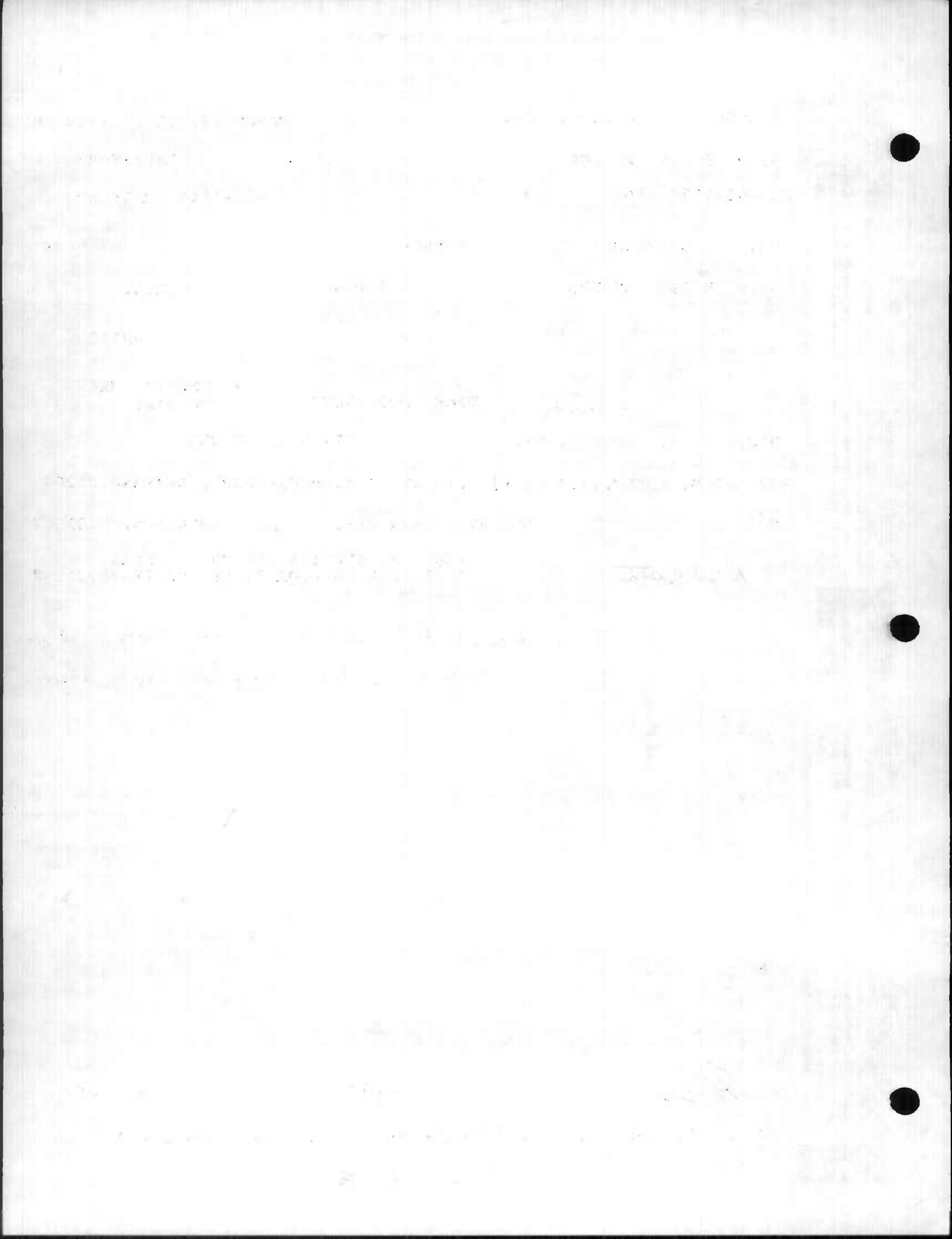
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09111

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard H Lewis

2. Date of Death

March 19, 2000

3. Time of Death

2:30 AM

4a. Facility Name (If not institution, give street and number)

St Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-20-8071

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

2/5/26

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1923 Fulton Ave

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (13 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Counselor

16b. Kind of Business/Industry

Public Health

17. Father's Name (First, Middle, Last)

Richard H. Lewis

18. Mother's Name (First, Middle, Maiden Summa)

Ada Ford

19a. Informant's Name/Relationship (Type, Print)

Delana Brooks - Nephew 1918 Greenhaven Dr. Balto, MD 21209

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

3/24/00 Cwings Mills, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Albert P. Wylie F.H.A.
638 N Gilmer St Balto, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction
Due to (or as a consequence of):

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lung Cancer
Due to (or as a consequence of):

one year

c. chronic obstructive pulmonary disease years
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P12595

29d. Date signed (Month, Day, Year)

March 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mustapha Mallah 900 caton Avenue, Baltimore, MD 21218

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Richard Lewis
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09112

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARTHA L MITCHELL

2. Date of Death

03

Day

13

Year

2000

3. Time of Death

1615

4a. Facility Name (If not institution, give street and number)

UMMS

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

212-74-1444

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

2/18/1906

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2909 Rosemar Drive

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (14 or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Ownhome

17. Father's Name (First, Middle, Last)

Peter McIntosh Bain

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ann Sheard

19a. Informant's Name/Relationship (Type, Print)

Barbara J. Mongold / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2925 Summit Circle, Ellicott City, Maryland 21043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

8/16/2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Lung Cancer
Due to (or as a consequence of):c. Deep Soft Tissue Infection
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous Myocardial Infarct

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

WI#34149

29d. Date signed (Month, Day, Year)

03-13-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chef Morrison

UMMS 22 3 Greene St. Balt. MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09113

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAURICE MYRTLE MOORE

2. Date of Death

MARCH 15 2000

3. Time of Death

11:35pm

4a. Facility Name (If not institution, give street and number)

4315 FERNHILL AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-22-9090

6. Sex

1 ☐ M 3 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02-28-06

9. Birthplace (State or Foreign Country)

SMITHFIELD, VA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4315 FERNHILL AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14-or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

CHARLIE ROBINSON

18. Mother's Name (First, Middle, Maiden Surname)

MAMMIE EDWARDS

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY JONES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4315 FERNHILL AVE, BALTO. MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

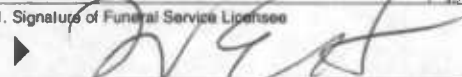
BALTIMORE NATIONAL

Date

3-21-2000 MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HOWELL FUNERAL HOME

4600 LIBERTY HGHTS AVE, BALTO. MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Cardiovascular disease

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerosis

years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Decubitus ulcer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Amatun H. Maqam, M.D.

29c. License number

D15503

29d. Date signed (Month, Day, Year)

March 20, 2000

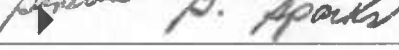
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUN H MAQAM, 501 Delphi St Balto MD 21217

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature


State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

④

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09114

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GRACE T. MC ELHATTAN				2. Date of Death Month Day Year March 19, 2000		3. Time of Death 5:20 P.M.	
	4a. Facility Name (If not institution, give street and number) Future Care Cherrywood				4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-44-8956		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) June 1, 1907	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Baltimore		10c. City, Town or Location Reisterstown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 13011 Old Hanover Road		10f. Zip Code 21136		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Issac T. Trager				18. Mother's Name (First, Middle, Maiden Surname) Grace E. Danner			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Debbye L. DiMarino Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13015 Old Hanover Rd., Reisterstown, MD 21136			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. Date 3/24/00		20d. Location - City or Town, State Pikesville, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CANCER BREAST Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 1/RS			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONCOMITANT ANTERIOR MYOCARDIAL INFARCTION HYPERTENSION				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D 20333		29d. Date signed (Month, Day, Year) 3/24/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. B. BAKER MD 1838 GREENBRIER RD Pikesville MD							
State Registrar	31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature <i>[Signature]</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09115

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mender Montgomery				2. Date of Death Month Day Year March 15, 2000		3. Time of Death 22:40	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 215-40-8132		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) 08-31-42	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1618 Hartsdale Road		10f. Zip Code 21239		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician		16b. Kind of Business/Industry Company		16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician		
17. Father's Name (First, Middle, Last) Eustace Thornton		18. Mother's Name (First, Middle, Maiden Surname) Effie Wall		19a. Informant's Name/Relationship (Type, Print) Darrell Montgomery		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1618 Hartsdale Road Baltimore, Maryland 21239		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 03-23-2000 Lansdowne, MD		20d. Date		
21. Signature of Funeral Service Licensee <i>Glenn M. Davis</i>		22. Name and Address of Facility Baltimore, Maryland 21202		22. Name and Address of Facility WM.C. March FH 1101 E. North Avenue		22. Name and Address of Facility Baltimore, Maryland 21202		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Metastatic Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Metastatic Colon Cancer Due to (or as a consequence of): Metastatic Colon Cancer Due to (or as a consequence of): Metastatic Colon Cancer Due to (or as a consequence of): Metastatic Colon Cancer		Approximate Interval Between Onset and Death 03 Days 02 yes		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year) 03-23-2000		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>R. Nelson MD</i>		
29c. License number RES-0000		29d. Date signed (Month, Day, Year) 3/15/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nelson 600 N. Wolfe St. Baltimore, MD 21287		31. Date filed (Month, Day, Year) MAR 21 2000		
32. Registrar's Signature <i>Barbara P. Sparks</i>		32. Registrar's Signature <i>Barbara P. Sparks</i>		32. Registrar's Signature <i>Barbara P. Sparks</i>		32. Registrar's Signature <i>Barbara P. Sparks</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Certificate of Death

Reg. No.

00 09116

ORIGINAL

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09117

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD PENDER JR				2. Date of Death Month Day Year MARCH 18 2000		3. Time of Death 9:43 am	
	4a. Facility Name (If not institution, give street and number) GREENSPRING NSG & REHAB CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-22-3127		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 23 1927	
	9. Birthplace (State or Foreign Country) NORTH CAROLINA		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1602 ASHBURTON STREET		10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 45/47		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRODUCE CLERK		16b. Kind of Business/Industry CULINARY		17. Father's Name (First, Middle, Last) EDWARD PENDER SR.	
	18. Mother's Name (First, Middle, Maiden Surname) IDA PARHAM		19a. Informant's Name/Relationship (Type, Print) Aline J. Pender/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Ashburton Street., Baltimore, Maryland 21216		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST		20c. Location - City or Town, State OWINGS MILLS, MARYLAND		21. Signature of Funeral Service Licensee		22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE RENAL FAILURE DAYS Due to (or as a consequence of): END STAGE RENAL DISEASE MONTHS Due to (or as a consequence of): HYPERTENSIVE CARDIOVASCULAR DNEASE YEARS Due to (or as a consequence of):		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier B.C. Veneracion Jr M.D. PA	
	29c. License number D13664		29d. Date signed (Month, Day, Year) March 20, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B.C. VENERACION JR M.D. PA, 1576 MERRITT BLVD, BALTO, MD. 21222		31. Date filed (Month, Day, Year) MAR 21 2000	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature B. Sparks		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09118

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NATHAN POWELL

2. Date of Death

Month Day Year
3 16 00

3. Time of Death

3:25 AM

4a. Facility Name (If not institution, give street and number)

HCR MANOR CARE AT RUXTON

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

230-22-5546

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 22, 1928

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

MARYLAND

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5508 WILVAN AVENUE

10f. Zip Code

21207

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 HIGH SCHOOL

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FOREMAN

16b. Kind of Business/Industry

CONTINENTAL CAN COMPANY

17. Father's Name (First, Middle, Last)

JOHN

POWELL

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE MAE FOSTER

19a. Informant's Name/Relationship (Type, Print)

MARY POWELL (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5508 WILVAN AVENUE, BALTIMORE, MD. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FOSTER FAMILY CEMETERY 03-25-00 EMPORIA, VIRGINIA

Date

03-25-00

20c. Location - City or Town, State

EMPORIA, VIRGINIA

21. Signature of Funeral Service Licensee

Richard N. Williams

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTO, MD. 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. SEPTICEMIA

Due to (or as a consequence of):

b. RENAL FAILURE

Due to (or as a consequence of):

c. ATRIAL FIBRILLATION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Approximate
Interval Between
Onset and DeathPhysician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Raymond A. Nemo

29c. License number

034154

29d. Date signed (Month, Day, Year)

3/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYMOND A. NEMO, 7801 YORK RD #100, TOWSON MD 21204

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

Benjamin A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09119

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET M. PETRELLA				2. Date of Death Month Day Year MARCH 17, 2000		3. Time of Death 6:15 A.M.	
	4a. Facility Name (If not institution, give street and number) COLLEGE MANOR, INC.				4b. City, Town, or Location of Death LUTHERVILLE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 217-48-1478		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) 5/5/1905	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE CITY	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1017 STILES STREET		10f. Zip Code 21202		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		15b. Kind of Business/Industry OWN HOME		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		
17. Father's Name (First, Middle, Last) ANTHONY CUNEO		18. Mother's Name (First, Middle, Maiden Surname) JOSEPHINE BACIGALUPO		19a. Informant's Name/Relationship (Type, Print) JOSEPH PETRELLA SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1848 DEVERON ROAD BALTIMORE, MD 21234		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOST HOLY REDEEMER CEM.		20c. Location - City or Town, State BALTIMORE, MD		20d. Date 3/22/2000		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypovolemia Due to (or as a consequence of): Poor oral intake, debility Due to (or as a consequence of): Advanced age, dementia Due to (or as a consequence of):		Approximate Interval Between Onset and Death		
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Constrictive heart failure		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) College Manor		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 024732		
29d. Data signed (Month, Day, Year) 3/17/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.T. Schweine MD 21 West Rd, Towson, MD 21204		31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09120

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINDA HARRELL-PERRERA				2. Date of Death Month Day Year MARCH 01, 2000		3. Time of Death 21:11 PM	
	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-48-3943	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3-25-1949		9. Birthplace (State or Foreign Country) VA.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County N/A	10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 652 PITCHER ST.			10f. Zip Code 21217		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (14 or 5+) -2-		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A			
	17. Father's Name (First, Middle, Last) ROBERT E. HARRELL SR.				18. Mother's Name (First, Middle, Maiden Surname) CORRINE SUTTON			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) RODRIGUEZ HARRELL (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1626 BRUCE CT. BALTIMORE, MARYLAND 21217			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. PARK		20c. Location - City or Town, State 3-21-2000 TIMONIUM, MARYLAND			
	21. Signature of Funeral Service Licensee <i>Swath J. Hibner</i>				22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic and cocaine intoxication Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
State Registrar	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 3-1-00		28b. Time of Injury Unk. M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred Unknown				28f. Location (Street and Number or Rural Route Number, City or Town, State) 628 N. Eutaw St., Baltimore, MD			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>J. Laron Locke MD</i>				29c. License number OCME		29d. Date signed (Month, Day, Year) MARCH 02, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke, M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature <i>B. Sparks</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09121

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAWRENCE W. RYAN				2. Date of Death Month Day Year March 16, 2000		3. Time of Death 1340	
	4a. Facility Name (If not institution, give street and number) 3511 SEAPINE CIRCLE				4b. City, Town, or Location of Death Randallstown		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 214-03-5623		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 15, 1917	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Randallstown		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 3511 SEAPINE CIRCLE				10f. Zip Code 21133		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERICAL		16b. Kind of Business/Industry Admin Social Security			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Thomas Henry Ryan				18. Mother's Name (First, Middle, Maiden Surname) MARIE Queen			
	19a. Informant's Name/Relationship (Type, Print) Carolyn Gadson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3514 Rockdale Ct. Balto. Md 21244			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS Cem.		20c. Date 3/23		20d. Location - City or Town, State GARRISON, Md.	
	21. Signature of Funeral Service Licensee Diana Adams		22. Name and Address of Facility Marshall W. Jones, Jr. RTH. P#2124 4101 Edmondson Ave Balto. Md					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease							Approximate Interval Between Onset and Death 40 years
	Due to (or as a consequence of): b.							
	Due to (or as a consequence of): c.							
	Due to (or as a consequence of): d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D18667		29d. Date signed (Month, Day, Year) March 19, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phil P. Militello, MD Shock Trauma 22 S. Greene St. Baltimore, MD 21201								
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature [Signature]						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09122.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Charles C. Riggin, Jr.</i>				2. Date of Death Month <i>March</i> Day <i>17</i> Year <i>00</i>		3. Time of Death <i>8:10 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Laurel Regional Hospital</i>				4b. City, Town, or Location of Death <i>Laurel</i>		4c. County of Death <i>Prince George</i>	
Funeral Director	5. Social Security Number <i>219-94-1688</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>35</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Oct. 26, 1964</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10. Usual Residence of Decedent 10a. State <i>Maryland</i> 10b. County <i>Anne Arundel</i> 10c. City, Town or Location <i>Hanover</i> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>education tech</i>		
16b. Kind of Business/Industry <i>federal government</i>		17. Father's Name (First, Middle, Last) <i>Charles C. Riggin, Sr.</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Linda L. Sheckells</i>		19. Informant's Name/Relationship (Type, Print) <i>Charles C. Riggin, Sr. - father</i>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7719 Pinyon Road, Hanover, Maryland 21076</i>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Meadowridge Memorial Park</i>		20c. Location - City or Town, State <i>Elkridge, Maryland</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Line Sepsis</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Diabetic Ketoacidosis, Respiratory Failure, Acute Encephalopathy, Hypertension, Insulin Dependent Diabetes Mellitus with neuroglycopenia, Chronic Renal Failure, Sepsis</i>		Approximate Interval Between Onset and Death <i>10 days</i>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetic Ketoacidosis, Respiratory Failure, Acute Encephalopathy, Hypertension, Insulin Dependent Diabetes Mellitus with neuroglycopenia, Chronic Renal Failure, Sepsis</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D46120</i>		29d. Date signed (Month, Day, Year) <i>March 19, 2000</i>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>F DeLeon 10724 Little Potomac Pkwy, Columbia, MD 21044</i>								
31. Date filed (Month, Day, Year) <i>MAR 21 2000</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09123

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John P. Romanowski

2. Date of Death
Month Day Year
March 19, 20003. Time of Death
4:20pm

4a. Facility Name (If not institution, give street and number)

VAMHCS Fort Howard Division

4b. City, Town, or Location of Death

Fort Howard

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214010777

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/22/1915

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2108 Boston ST.

10f. Zip Code

21231

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Peter Romanowski

18. Mother's Name (First, Middle, Maiden Surname)

Constance Kropkowski

19a. Informant's Name/Relationship (Type, Print)

John J. Romanowski / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1201 Turnbridge Rd. Forest Hill, MD 21050

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Stanislaus Cem.

Date

3/23

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Moran-Ashton-Dabrowski Funeral Home, Inc.
3000 E. Baltimore St. Baltimore, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

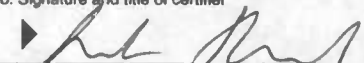
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D57239

29d. Date signed (Month, Day, Year)

March, 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Shandelya, MD 9600 North Point Road, Fort Howard, MD 21052

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

State
RegistrarName: John P. Romanowski
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 5,10e per fh G781 3/27/00 yg

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09124

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA REED

2. Date of Death

MARCH SEVENTEEN '00

3. Time of Death

5:35 PM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

219-10-7830

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06-20-20

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1307 N. KENWOOD AVENUE
~~1309 N. Kenwood Avenue~~

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th GradeCollege (1-4 or 5+)
NA16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

other people homes

17. Father's Name (First, Middle, Last)

Percy Harriston

18. Mother's Name (First, Middle, Maiden Surname)

Lucinda Adams

19a. Informant's Name/Relationship (Type, Print)

Marian E. Campbell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

511 E. 23rd. Street Baltimore, Maryland 21218

20a. Method of Disposition

X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Mem. Pk. Cem. 03-23-2000 Randallstown, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

A. Valencia Holland

22. Name and Address of Facility Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. MASSIVE PULMONARY EMBOLISM

Due to (or as a consequence of):

c. DEEP VENOUS THROMBOSIS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dua MD

29c. License number

P11400

29d. Date signed (Month, Day, Year)

MARCH SEVENTEEN 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUA, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD 21239.

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

Benita B. Sparks

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09125

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARLIE REESE III				2. Date of Death Month Day Year MARCH 15, 2000		3. Time of Death 1158 PM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-86-4451		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) 2-5-1962	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MD.		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits	
	10e. Street and Number 3500 COTTAGE AVE.		10f. Zip Code 21215		10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -11- College (1-4 or 5+) -0-		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry CLEANING			
	17. Father's Name (First, Middle, Last) CLEVELAND MORRIS		18. Mother's Name (First, Middle, Maiden Surname) THOMASINA PORTER					
	19a. Informant's Name/Relationship (Type, Print) THOMASINA MORRIS(MOTHER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 COTTAGE AVE. BALTIMORE, MARYLAND 21215					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK		20c. Location - City or Town, State 3-18-2000 BALTIMORE, MARYLAND			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COCAINE TOXICITY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES HYPERTENSION		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 03/04/2000		
28b. Time of Injury UNKNOWN M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) DWELLING		
28f. Location (Street and Number or Rural Route Number, City or Town, State) 3600 PARK HEIGHTS AVENUE BALTIMORE, MARYLAND		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		
29d. Date signed (Month, Day, Year) MARCH 20, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09126

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LYNETTE JEAN RACINE

2. Date of Death
Month Day Year
MARCH 12, 20003. Time of Death
7:00 AM

4a. Facility Name (If not institution, give street and number)

GENESIS ELDERCARE HERITAGE NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

213-52-0697

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Apr 11, 1931

9. Birthplace (State or Foreign Country)

South Africa

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28 Cool Breeze Drive

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (13-16)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

nurse

16b. Kind of Business/Industry

health

17. Father's Name (First, Middle, Last)

Thomas William White

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Irene Mills

19a. Informant's Name/Relationship (Type, Print)

Moira E. Brown/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

229 Currie Rd, Durban, Natal, S. Africa 4001

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

3/21/2000

20c. Location - City or Town, State

Baltimore MD.

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

NON SMALL CELL CARCINOMA OF LUNG

1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

10 YEARS

Due to (or as a consequence of):

CORONARY ARTERY DISEASE

18 YEARS

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harjit Singh MD.

29c. License number

D14160

29d. Date signed (Month, Day, Year)

MARCH 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARJIT SINGH MD. 510-A RITCHIE HIGHWAY, BALTIMORE
MARYLAND- 21225.

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-585-0000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09127

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosalee E. Shifflett				2. Date of Death Month Day Year March 20 2000		3. Time of Death 1410				
	4a. Facility Name (If not institution, give street and number) St Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 243-52-7460		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 5, 1932		9. Birthplace (State or Foreign Country) South Carolina		
	Usual Residence of Decedent										
10a. State Maryland		10b. County n/a		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 2018 Deering Avenue				10f. Zip Code 21230		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (14 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) bar maid			16b. Kind of Business/Industry bar and restaurant				
17. Father's Name (First, Middle, Last) Walter Crout					18. Mother's Name (First, Middle, Maiden Surname) Leola Evans						
19a. Informant's Name/Relationship (Type, Print) Ann E. Shifflett - daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2018 Deering Avenue, Baltimore, Maryland 21230						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Memorial Gardens			20c. Location - City or Town, State Marriottsville, MD		20d. Date 3/24/00			
21. Signature of Funeral Service Licensee Ann Y. Zink					22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229						
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Acidemia Due to (or as a consequence of): b. Hyperosmolar Coma Due to (or as a consequence of): c. Hypoglycemia Due to (or as a consequence of): d. Diabetes Mellitus										Approximate Interval Between Onset and Death hours hours days years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Shawn Michael Pettall					29c. License number P-12599		29d. Date signed (Month, Day, Year) March 20, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shawn Michael Pettall 900 Caton Avenue Baltimore, Maryland											
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature Shawn B. Sparks									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09128

Amended Item#17 per FHG781 3/21/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phoebe August Senior				2. Date of Death Month 03 Day 20 Year 00		3. Time of Death 11:00 PM	
	4a. Facility Name (If not institution, give street and number) 1425 N. LUZERNE ST				4b. City, Town, or Location of Death BALTO		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-40 4576		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 11-12-1916	
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTO	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1425 N. LUZERNE ST		10f. Zip Code 21213		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE College (14 or 5+) MASTER DEGREE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER		16b. Kind of Business/Industry SCHOOL		16c. City or Town, State BALTO. CITY PUBLIC		
17. Father's Name (First, Middle, Last) GEORGE VERRETT				18. Mother's Name (First, Middle, Maiden Surname) BLANCHE HILL				
19a. Informant's Name/Relationship (Type, Print) GEORGE VERRETT				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5007 TRUESDALE AVE BALTO MD 21206				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEM PK		20c. Location - City or Town, State 3/24/00 ARBUTUS MD.		20d. Date		
21. Signature of Funeral Service Licensee General Cromartie				22. Name and Address of Facility BETTS FUNERAL HOME 21213 1129 N. CAROLINE ST BALTO. MD				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Marc D. Sokolow Attending Physician				29c. License number D26534		29d. Date signed (Month, Day, Year) 03/21/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marc D. Sokolow M.D. 301 St. Paul Place Baltimore, MD 21202								
31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature Beverly G. Sparks				

ORIGINAL

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

VERNON STEPNEY

State of Maryland / Department of Health and Mental Hygiene

Amended Item#19b per FHG781 3/21/2000 EW

Certificate of Death

Reg. No.

00 09129

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and consulted in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician / Medical Examiner		1. Decedent's Name (First, Middle, Last) Vernon Stepney				2. Date of Death Month MARCH Day 16 , Year 2000		3. Time of Death 0337 AM	
Funeral Director		4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
5. Social Security Number 217-38-5132		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) 12 12 42		9. Birthplace (State or Foreign Country) M.D.	
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3910 Groveland Ave				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) na				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Improvement		16b. Kind of Business/Industry Self Employed Self Employed			
17. Father's Name (First, Middle, Last) Charles H. Stepney				18. Mother's Name (First, Middle, Maiden Surname) Mary Blackwell					
19a. Informant's Name/Relationship (Type, Print) Mary Brown-Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1836 Metzert Rd. Unit 1922, Adelphi Md 20783					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 3-21-00 Baltimore, Md		20d. Date	
21. Signature of Funeral Service Licensee <i>Shannon Spikes</i>				22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. STABWOUND OF CHEST Due to (or as a consequence of):				Approximate Interval Between Onset and Death					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 3-16-00		28b. Time of Injury 0300 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SHOOTING W/ STABBED.	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE						28f. Location (Street and Number or Rural Route Number, City or Town, State) 3910 GROVELAND AVE BALTIMORE MD	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Wayne McNeil</i>				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 16, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY PETERSON A. KOROS 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature <i>B. Sparks</i>							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09130

AMEND ITEMS: #20B,C PER F.H. G781 3-22-2000

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Angela V. Shell				2. Date of Death Month Day Year March 16 2000		3. Time of Death 13:30	
	4a. Facility Name (If not institution, give street and number) University of Maryland				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 216-78-2588		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 04-20-63	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State Md		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2034 N. Bentalou Street				10f. Zip Code 21216		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High Sch. Grad College (14 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Secretary		16b. Kind of Business/Industry Howard Univ. Hosp.		
17. Father's Name (First, Middle, Last) John W. Shell				18. Mother's Name (First, Middle, Maiden Surname) Judy Paye				
19a. Informant's Name/Relationship (Type, Print) Belinda Shell				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1520 Kirkwood Road Baltimore, Maryland 21207				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Gardens		Date 03-22-2000		20c. Location - City or Town, State MD RANDALLSTOWN, MD		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiorgan System Failure Due to (or as a consequence of): b. Complications of Liver Transplantation Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Nader Habashi				29c. License number D3055		29d. Date signed (Month, Day, Year) March 16, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NADER HABASHI 22 S. GREENE ST BALTIMORE MARYLAND								
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Sidney A. Smith		2. Date of Death Month Day Year March 16, 2000		3. Time of Death 12:25 A.M.		
4a. Facility Name (If not institution, give street and number) 5428 Bucknell Road		4b. City, Town, or Location of Death Baltimore		4c. County of Death NA		
5. Social Security Number 579-78-7318	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 04-29-59	
9. Birthplace (State or Foreign Country) DC						
Usual Residence of Decedent						
10a. State MD	10b. County NA	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 5428 Bucknell Road		10f. Zip Code 21206		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) 6yrs. BA Degree				
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher's Assistant Private School		16b. Kind of Business/Industry				
17. Father's Name (First, Middle, Last) Adrain Smith		18. Mother's Name (First, Middle, Maiden Surname) Odessa Davis				
19a. Informant's Name/Relationship (Type, Print) Wennie Smith		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1521 N. Broadway Baltimore, Maryland 21213				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington Nat'l Cem.		20c. Location - City or Town, State DC		
20d. Date 03-21-2000		21. Signature of Funeral Service Licensee <i>Odessa M. Davis</i>				
22. Name and Address of Facility Baltimore, Maryland 21202		22. Name and Address of Facility WM.C.March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Diabetic Cardio myopathy Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes Mellitus						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>S. Aaron Locke, MD</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 16, 2000		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) S. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature <i>B. Sparks</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09132

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lamont G. Saunders, Sr.				2. Date of Death Month Mar Day 15 Year 2000		3. Time of Death 10 PM			
	4a. Facility Name (If not institution, give street and number) Levindale Nursing Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA			
Funeral Director	5. Social Security Number 218-62-4133		6. Sex <input type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 43		8. Date of Birth (Month, Day, Year) 03-15-57			
	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 213 N. Dallas Street				10f. Zip Code 21213		10g. Citizen of What Country? USA				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security			16b. Kind of Business/Industry Liberty Medical Ctn			
17. Father's Name (First, Middle, Last) Charles Saunders					18. Mother's Name (First, Middle, Maiden Surname) Evelyn Thompson					
19a. Informant's Name/Relationship (Type, Print) Inez Brown					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1425 N. Potomac Street Baltimore, Maryland					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 03-21-2000 Lansdowne, MD					
21. Signature of Funeral Service Licensee Wladimir W. March					22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. End stage multiple sclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 days 2 years		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Dr. Rajani					29c. License number D49817		29d. Date signed (Month, Day, Year) MARCH 16th 2000.			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Rajani 2434 W Belvedere Ave, Baltimore -										
31. Date filed (Month, Day, Year) MAR 21 2000			32. Registrar's Signature Shirley B. Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09133

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joan Elizabeth Schrenker

2. Date of Death

Month

Day

Year

MARCH 15 2000

5:30 P.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE Hospital Center

4b. City, Town, or Location of Death

Rose Dale

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

216 32 7133

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

October 3, 1933

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Elmont Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Housekeeping-Own Home

17. Father's Name (First, Middle, Last)

Frank Weber

18. Mother's Name (First, Middle, Maiden Surname)

Marie Gossman

19a. Informant's Name/Relationship (Type, Print)

John A Schrenker (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Elmont Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St Joseph Ch. Cem. March 18, 2000

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kathleen Gossman Choracki

22. Name and Address of Facility

Lassan Funeral Home, Inc

7401 Belair Road Baltimore, Maryland 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Emphysema

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism, Diabetes Mellitus

Congestive Heart Failure

Morbid Obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marco Zamora, MD

29c. License number

D40819

29d. Date signed (Month, Day, Year)

MARCH 15 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MARCO ZAMORA 9000 FRANKLIN SQUARE DR. BALTIMORE, Md. 21237

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09134

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH STALEY

2. Date of Death
Month Day Year
MARCH 19 20003. Time of Death
1:45pmFuneral
Director

4a. Facility Name (If not institution, give street and number)

RAINBOW HALL

4b. City, Town, or Location of Death

OWINGS MILLS

4c. County of Death

BALTIMORE

5. Social Security Number

061-32-6818

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 YRS

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06/21/1908

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1341 WEST 41ST ST.

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

18e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

MISSIONARY

16b. Kind of Business/Industry

MISSIONARY

17. Father's Name (First, Middle, Last)

HARRY STALEY

18. Mother's Name (First, Middle, Maiden Surname)

LILIAN STEVENS

19a. Informant's Name/Relationship (Type, Print)

RICHARD HAINES (FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

128 HAWTHORNE AVE. PIKESVILLE, MD. 21208.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESLEY CHURCHYARD 03/22/2000 ROCK HALL, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D41104

29d. Date signed (Month, Day, Year)

3 21 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE C. HOUK M.D. 7825 YORK RD. BALTO., MD. 21204.

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

RKD
00-1536-027
OSCAR
SIMMONS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09135

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OSCAR H SIMMONS				2. Date of Death Month Day Year MARCH 15, 2000		3. Time of Death 12:32P.M.	
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 347-34-1771		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) March 11 1943	
	9. Birthplace (State or Foreign Country) Tennessee		10a. State MD		10b. County Baltimore		10c. City, Town or Location Middle River	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5 Emala Ave.		10f. Zip Code 21220		
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mover		16b. Kind of Business/Industry Moving Connection		
17. Father's Name (First, Middle, Last) George Lee Simmons				18. Mother's Name (First, Middle, Maiden Surname) Lera Mae Oliver				
19a. Informant's Name/Relationship (Type, Print) Diana Simmons / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Emala Ave. Baltimore Md. 21220				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery 3/18/2000		20c. Location - City or Town, State Baltimore MD				
21. Signature of Funeral Service Licensee B. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221				
23a. Part I. Enter the disease, or conditions that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Maryanne DelBello				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 16, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryanne DelBello 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-0004.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09136

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SOLOMON SNYDER

2. Date of Death

March 18, 2000

3. Time of Death

7:00 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

216-12-9935

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV 4 1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

513 NASSAU STREET

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LEGISLATIVE ANALYST

16b. Kind of Business/Industry

DEPT OF LABOR

17. Father's Name (First, Middle, Last)

DAVID

SNYDER

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

GOLDMAN

19a. Informant's Name/Relationship (Type, Print)

LILLIAN SNYDER/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

513 NASSAU STREET BALTIMORE MARYLAND 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH EL MEMORIAL PARK

Date

3/20/00

20c. Location - City or Town, State

RANDALLSTOWN, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. FUNGAL SEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC CA of COLON

CHF

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44705

29d. Date signed (Month, Day, Year)

March 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. J. J. Imperia Jr. - NWHE

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09137

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Thompson				2. Date of Death Month March Day 16 Year 2000		3. Time of Death 22:12	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-40-1749		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) 10-28-43	
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 4008 CENTRE RD.		10f. Zip Code 21206	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -10- College (1-4 or 5+) -0-	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISABLED				16b. Kind of Business/Industry N/A		17. Father's Name (First, Middle, Last) CHARLES THOMPSON	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) RUBY BUGGS				19a. Informant's Name/Relationship (Type, Print) PAULA R. THOMPSON (WIFE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4008 CENTRE RD. BALTIMORE, MARYLAND 21206	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VETERANS 3-22-2000 OWINGS MILLS, MARYLAND		20c. Location - City or Town, State	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Laatha D. Hines				22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Pulmonary Edema Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Small intestinal obstruction secondary to adhesions with gangrenous segment				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23c. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24a. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Donald W Edlow, M.D.		29c. License number D0002569	
	29d. Date signed (Month, Day, Year) March 17, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD W EDLOW, M.D. GOOD SAMARITAN HOSPITAL, BALTIMORE, MD 21239			
State Registrar	31. Date filed (Month, Day, Year) MAR 21 2000				32. Registrar's Signature James B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09138

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marshall J. Trail

2. Date of Death

Month Day Year
March 16, 2000

3. Time of Death

11:10 AM

4a. Facility Name (If not institution, give street and number)

Colton Villa Nursing Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

216-14-6426

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 29, 1906

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hancock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13838 White Oak Ridge

10f. Zip Code

21750

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

William Nathan Trail

18. Mother's Name (First, Middle, Maiden Surname)

Helen Mae Norris

19a. Informant's Name/Relationship (Type, Print)

Merle L. Trail, Sr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13918 White Oak Ridge Hancock, MD 21750

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Piney Plains Cemetery

Date

3/18/2000

20c. Location - City or Town, State

Little Orleans, MD

21. Signature of Funeral Service Licensee

Richard S. Jones

22. Name and Address of Facility

Grove Funeral Home, P.A.
141 W. Main St. Hancock, MD 21750-0368

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE MIWS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c. Cerebro VASCULAR ACCIDENT

Due to (or as a consequence of):

d. _____

2 day.

3 weeks.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Manyan J. Hay

29c. License number

D28365

29d. Date signed (Month, Day, Year)

3-16-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAN 2 AR. J. SHAPI. 368 MILL ST. HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

Benjamin B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09139

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gilbert

2. Date of Death

Month

Day

Year

March 16, 2000

3. Time of Death

15:45

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220 24 3605

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5/19/29

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10 ACORN CIRCLE APT. 102

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8TH GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ABLE BODY SEAMAN

16b. Kind of Business/Industry

MERCHANT MARINE

17. Father's Name (First, Middle, Last)

JOHN APTEL WOLF

18. Mother's Name (First, Middle, Maiden Surname)

LORRAINE WISNER

19a. Informant's Name/Relationship (Type, Print)

NANCY WOLFE WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 ACORN CIRCLE APT. 102 TOWSON, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH CEM.

Date

3/20/2000 PARKVILLE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Heather N. Hay

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic cardiomyopathy

Due to (or as a consequence of):

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Andrea L. Cox MDPKD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

March 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrea L. Cox MDPKD 601 North Caroline Street Baltimore Maryland 21287

31. Date filed (Month, Day, Year)

MAR 21 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09140

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRIEDA LENORA WEINBERG						2. Date of Death Month March Day 16th Year 2000		3. Time of Death 2:30 pm	
	4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON						4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 578-09-4922		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) DEC 1 1915		9. Birthplace (State or Foreign Country) RUSSIA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 8715 1ST AVE. APT. 703-D				10f. Zip Code 20910		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) MORRIS GASS						18. Mother's Name (First, Middle, Maiden Surname) LILLIAN (UNOBTAINABLE)			
	19a. Informant's Name/Relationship (Type, Print) HOWARD WEINBERG/NEPHEW						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7224 CADENCE CT. COLUMBIA, MD. 21046			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GARDENS		Date 3/19/00		20c. Location - City or Town, State FALLS CHURCH, VA.			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardio - pulmonary arrest Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast carcinoma anxiety chronic cerebral recurrent osteoporosis peripheral vascular disease									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number D:44907		29d. Date signed (Month, Day, Year) March 16th 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Road Rockville, MD 20852									
	31. Date filed (Month, Day, Year) MAR 21 2000		32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09141

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marilyn P. Yetso				2. Date of Death Month Day Year March 17, 2000		3. Time of Death 9:20pm	
	4a. Facility Name (If not institution, give street and number) 11422 Barrow Downs				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 167-34-2876		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Oct 24, 1942	
	9. Birthplace (State or Foreign Country) Ohio		10a. State MD.		10b. County Howard		10c. City, Town or Location Columbia	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 11422 Barrow Downs		10f. Zip Code 21044	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker				16b. Kind of Business/Industry own home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) William C. Petrosky				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Halbert			
	19a. Informant's Name/Relationship (Type, Print) Stephen J. Yetso, husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11422 Barrow Downs, Columbia, Md. 21044			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Memorial Gard.		20c. Location - City or Town, State 3/23/00 Marriottsville, MD.	
	21. Signature of Funeral Service Licensee Theresa L. Remmer				22. Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Rd., Columbia, Md. 21045			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. metastatic Colon Cancer				Approximate Interval Between Onset and Death 2 weeks			
	Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2/A							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2/A				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier Dr. C. Knight				29c. License number D 41139		29d. Date signed (Month, Day, Year) March 20th, 2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Clement Knight, M.D., 11065 Little Patuxent Pkwy., Columbia, Md. 21044				31. Date filed (Month, Day, Year) MAR 21 2000			
	32. Registrar's Signature Denise B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09142

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kelvin Louis Adore				2. Date of Death Month Day Year March 9, 2000				3. Time of Death 10:10 am	
	4a. Facility Name (If not institution, give street and number) 8505 Springvale Road #13				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 216-60-2389		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 10, 1923		9. Birthplace (State or Foreign Country) Trinidad	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 8505 Springvale Road #13				10f. Zip Code 20910		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse				16b. Kind of Business/Industry Medical			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Patrick Vincent Adore				18. Mother's Name (First, Middle, Maiden Surname) Juanita Blackman					
	19a. Informant's Name/Relationship (Type, Print) Charlene Adore (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11451 Cherry Hill Road #401 Beltsville, Maryland 20705					
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, Maryland		20d. Date Mar. 13 2000	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901					
Physician /Medical Examiner	23a. Pertinent - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary Arrest Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Insufficiency									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number 745796		29d. Date signed (Month, Day, Year) 3/10/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clayton Strouhn, M.D. 1400 Spring Street Silver Spring, Maryland 20910									
31. Date filed (Month, Day, Year) MAR 10 2000										
32. Registrar's Signature 										

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09143

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

KHALID MOHSAIN ALOTAIBI

2. Date of Death

Month

MARCH

Day

3

Year

2000

3. Time of Death

1:35 AM

4a. Facility Name (If not Institution, give street and number)

National Institutes of Health

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

N/A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 18, 1963

9. Birthplace (State or Foreign Country)

Saudi Arabia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9000 Rockville Pike

10f. Zip Code

20892

10g. Citizen of What Country?

Saudi Arabia

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Business

16b. Kind of Business/Industry

Car Sales

17. Father's Name (First, Middle, Last)

Mohsen Al-Otaibi

18. Mother's Name (First, Middle, Maiden Summa)

Noura Al-Otaibi

19a. Informant's Name/Relationship (Type, Print)

Col. Sulaiman Al-Bassam/Director

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1001 30th St., N.W. Washington, D.C. 20007

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riyadh Cemetery

Date

March 6, 2000

20c. Location - City or Town, State

Riyadh, Saudi Arabia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

2222 Wisconsin Ave., N.W.

Washington, D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septic shock, Pneumonia

Due to (or as a consequence of):

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aplastic Anemia

Due to (or as a consequence of):

4 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dorothea McAreavey

29c. License number

D00045922MD

29d. Date signed (Month, Day, Year)

030300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOROTHEA MCAREAVEY

9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09144

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK RICHARD ATEN						2. Date of Death Month Day Year MARCH 5, 2000		3. Time of Death 20:42		
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL						4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 165 07 8265		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 10, 1915		9. Birthplace (State or Foreign Country) NEW JERSEY		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location SANDY SPRING				10d. Inside City Limits 1 Yes 2 No		
	10e. Street and Number 17300 QUAKER LANE A-D6				10f. Zip Code 20860		10g. Citizen of What Country? UNITED STATES				
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PURCHASING AGENT				16b. Kind of Business/Industry AIRCRAFT				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) FRANK W. ATEN						18. Mother's Name (First, Middle, Maiden Surname) MAUD RACHEL TINSMAN				
	19a. Informant's Name/Relationship (Type, Print) SALLY S. OGDEN, DAUGHTER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 775 RIVER ROAD, SYKESVILLE, MD. 21784				
	20e. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		Date 3/8/00		20c. Location - City or Town, State ALEXANDRIA, VA.		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882						
Physician /Medical Examiner	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PULMONARY EMBOLUS								Approximate Interval Between Onset and Death MINUTES		
	Due to (or as a consequence of):										
	Due to (or as a consequence of):										
	Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AORTIC STENOSIS CORONARY ARTERY DISEASE								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D38457		29d. Date signed (Month, Day, Year) MARCH 6, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) N. GOYAR MD 3801 INTERNATIONAL DR #211, SILVER SPRING MD 20906											
31. Date filed (Month, Day, Year) MAR 09 2000				32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09145

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emily Mae Biggs				2. Date of Death Month Day Year March 1, 2000		3. Time of Death 1320																										
	4a. Facility Name (If not institution, give street and number) Lauralwood Center				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil																										
Funeral Director	5. Social Security Number 214-03-5528		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) April 27, 1907																										
	Usual Residence of Decedent		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Cecilton																										
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number Center Street - Earleton Village		10f. Zip Code 21913		10g. Citizen of What Country? United States																										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic - Own Home																												
	17. Father's Name (First, Middle, Last) Jamaes Loller				18. Mother's Name (First, Middle, Maiden Surname) Emma Craig																												
	19a. Informant's Name/Relationship (Type, Print) R. Nelson Biggs - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Montpelier Drive, New Castle, Delaware 19720																												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Zion Cemetery - March 6th, 2000		20c. Location - City or Town, State Cecilton, Maryland																												
	21. Signature of Funeral Service Licensee William L. King Jr. M-00934				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 226 East Main St., PO Box 342, Cecilton, Maryland 21913																												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Sepsis Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 1 Day</td> </tr> <tr> <td>b. Recurrent Urinary Tract Infection Due to (or as a consequence of):</td> <td>3 MONTHS</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Sepsis Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 Day	b. Recurrent Urinary Tract Infection Due to (or as a consequence of):	3 MONTHS	c. Due to (or as a consequence of):		d. Due to (or as a consequence of):																	
	Immediate Cause (Final disease or condition resulting in death)	a. Sepsis Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 Day																														
b. Recurrent Urinary Tract Infection Due to (or as a consequence of):		3 MONTHS																															
c. Due to (or as a consequence of):																																	
d. Due to (or as a consequence of):																																	
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="2">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																													
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																											
<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																															
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																													
<table border="1"> <tr> <td colspan="8">29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="4">29b. Signature and title of certifier Monte Makous, MD</td> <td colspan="2">29c. License number D-44783</td> <td colspan="2">29d. Date signed (Month, Day, Year) March 2, 2000</td> </tr> </table>								29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier Monte Makous, MD				29c. License number D-44783		29d. Date signed (Month, Day, Year) March 2, 2000											
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29b. Signature and title of certifier Monte Makous, MD				29c. License number D-44783		29d. Date signed (Month, Day, Year) March 2, 2000																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monte Makous, MD 111 West High Street, ELKTON, MD 21921																																	
31. Date filed (Month, Day, Year) MAR 03 2000				32. Registrar's Signature B. Sparks																													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09146

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marjorie F. Bals				2. Date of Death Month Day Year March 4, 2000		3. Time of Death 4:50A.	
	4a. Facility Name (If not institution, give street and number) 7419 Flamewood Drive				4b. City, Town, or Location of Death Clarksville		4c. County of Death Howard	
Funeral Director	5. Social Security Number 269-36-7963	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 26, 1941		9. Birthplace (State or Foreign Country) Alliance, Ohio
	Usual Residence of Decedent							
10a. State Maryland		10b. County Howard		10c. City, Town or Location Clarksville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 7419 Flamewood Drive				10f. Zip Code 21029		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Flight Attendant			16b. Kind of Business/Industry United Airlines	
17. Father's Name (First, Middle, Last) James Mervin Hull				18. Mother's Name (First, Middle, Maiden Surname) Flora Marjorie Ward				
19a. Informant's Name/Relationship (Type, Print) Mildred L. Keller (sister in law)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1 Deerfield, Ohio 44411				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 3/5/2000			20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee <i>Donald V. Borgwardt</i>				22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 years Approximate Interval Between Onset and Death 3 years								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier <i>Leon Hyang</i>				29c. License number D45880		29d. Date signed (Month, Day, Year) March 4, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon Hyang, M.D. 10400 Connecticut Avenue, #606 Kensington, Maryland 20895								
State Registrar	31. Date filed (Month, Day, Year) MAR 08 2000				32. Registrar's Signature <i>B. Sparks</i>			

ORIGINAL

2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09147

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MINNIE BANE				2. Date of Death Month Day Year MARCH 2, 2000				3. Time of Death 3:30 AM		
	4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 577.42.2677		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 15, 1907		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 6121 MONTROSE ROAD				10f. Zip Code 20852				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME			
17. Father's Name (First, Middle, Last) LEWIS GLASSMAN				18. Mother's Name (First, Middle, Maiden Surname) ANNIE MENDELSON							
19a. Informant's Name/Relationship (Type, Print) ELINOR ZEVIN/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 WHITLEY PARK TERRACE #502, BETHESDA, MD 20814							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GDNS		Date March 5, 2000		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE MYO CARDIAL INFARCTION								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
		28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number D24942		29d. Date signed (Month, Day, Year) MAR 2, 2000					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD											
31. Date filed (Month, Day, Year) MAR 06 2000				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09148

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernard Murray Beall				2. Date of Death Month Day Year March 3, 2000		3. Time of Death 5:20 AM								
	4a. Facility Name (If not institution, give street and number) Althea Woodland Nursing Home				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery								
Funeral Director	5. Social Security Number 217-18-8816		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) July 30, 1924								
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring								
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1000 Daleview Drive		10f. Zip Code 20901		10g. Citizen of What Country? United States								
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW-II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Public Relations Manager		16b. Kind of Business/Industry AARP										
	17. Father's Name (First, Middle, Last) Charles W. Beall				18. Mother's Name (First, Middle, Maiden Surname) Clara Coursey										
	19a. Informant's Name/Relationship (Type, Print) Lemuel D. Beall Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3324 Clay Street Silver Spring, MD 20902										
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium		20c. Location - City or Town, State Bethesda, Maryland										
	21. Signature of Funeral Service Licensee <i>John P. Chapman</i> M00092		22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Pneumonia</td> <td rowspan="4"> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death 1 month </td> </tr> <tr><td>b.</td></tr> <tr><td>c.</td></tr> <tr><td>d.</td></tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumonia	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 month	b.	c.	d.
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumonia	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 month											
b.															
c.															
d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease Stroke															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined															
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier Oki Kwon, M.D. 29c. License number D 30927 29d. Date signed (Month, Day, Year) March 3, 2000															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oki Kwon M.D. 1104 Spring Street #201, Silver Spring, Maryland 20910															
31. Date filed (Month, Day, Year) MAR 06 2000 32. Registrar's Signature <i>B. Sparks</i>															

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Ronald Edward Bennett

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, II, 27 PER MEO G781 3-22-2000 WR.
Amended #7, 3/9/2000, JW, Mont. Co.

Certificate of Death

Reg. No.

00 09150

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Edward Bennett				2. Date of Death Month Day Year March 04, 2000		3. Time of Death 9:15 A.M.		
	4a. Facility Name (If not institution, give street and number) 9520 Rhode Island Avenue				4b. City, Town, or Location of Death College Park		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 577-48-2445	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) Dec. 30, 1933		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
10a. State MD		10b. County Prince George's		10c. City, Town or Location College Park		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 9520 Rhode Island Avenue				10f. Zip Code 20740		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-1959		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cartographer		16b. Kind of Business/Industry U.S. Government			
17. Father's Name (First, Middle, Last) Ronald David Bennett				18. Mother's Name (First, Middle, Maiden Surname) Mae Elizabeth Emerson					
19a. Informant's Name/Relationship (Type, Print) Sallie D. Bennett (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Mariners Way Stevensville, MD 21666					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		Date 3/9/00		20c. Location - City or Town, State Shenandoah, VA			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street Alexandria, VA 22310					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ALCOHOLISM						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 05, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute mo 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09151

Certificate of Death

Reg. No.

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

ANN HARRINGTON BIGLEY

2. Date of Death

March 4, 2000

3. Time of Death

4:07 PM

4a. Facility Name (If not institution, give street and number)

National Naval Medical Center

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-40-1828

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 14, 1928

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Vienna

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1329 Carpers Farm Way

10f. Zip Code

22182-1348

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Elliott Harrington

18. Mother's Name (First, Middle, Maiden Surname)

Mary Flynn

19a. Informant's Name/Relationship (Type, Print)

VADM Thomas J. Bigley/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1329 Carpers Farm Way Vienna, Virginia 22182-1348

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cem.

Date

Mar. 10,
2000

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home
2222 Wisconsin Ave. N.W.
Washington, D.C. 2000723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cancer of the Esophagus

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

4812020

29d. Date signed (Month, Day, Year)

March 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carolyn McMonigle 8901 Wisconsin Ave. Bethesda, Maryland 20889

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

Dorothy B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
(Medical
Examiner)

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09152.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KLAUS HERBERT BINDER				2. Date of Death Month Day Year MARCH 3, 2000		3. Time of Death 12:31													
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY													
Funeral Director	5. Social Security Number 084 28 5454		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APR. 13, 1936	9. Birthplace (State or Foreign Country) GERMANY												
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location OLNEY		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
	10e. Street and Number 18815 CLOVERHILL LANE				10f. Zip Code 20832		10g. Citizen of What Country? UNITED STATES													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1958-1959		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER		16b. Kind of Business/Industry TECHNOLOGY															
	17. Father's Name (First, Middle, Last) HERMANN BINDER				18. Mother's Name (First, Middle, Maiden Surname) MARIA NABER															
	19a. Informant's Name/Relationship (Type, Print) RUTH BINDER, WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18815 CLOVERHILL LANE, OLNEY, MD. 20832															
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		Date 3/4/00		20c. Location - City or Town, State ALEXANDRIA, VA.													
	21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Cerebral bleed</td> <td>7 days</td> </tr> <tr> <td>b.</td> <td>Acute left hemispheric stroke</td> <td>7 days</td> </tr> <tr> <td>c.</td> <td>Hypertension</td> <td>10 years</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	Cerebral bleed	7 days	b.	Acute left hemispheric stroke	7 days	c.	Hypertension	10 years	d.	
Immediate Cause (Final disease or condition resulting in death)	a.	Cerebral bleed	7 days																	
	b.	Acute left hemispheric stroke	7 days																	
	c.	Hypertension	10 years																	
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Transient Ischemic Attack						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																
28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. Signature and title of certifier D. J. [Signature] MD				29c. License number D51908		29d. Date signed (Month, Day, Year) March 3 2000														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doris [Signature] MD 1811 Prince Phillip Drive Suite 327 Olney Maryland																				
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature [Signature]																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

2041

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09153

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Eleanor Brett Bronaugh					2. Date of Death Month Feb. Day 29, Year 2000		3. Time of Death 5:45 AM.	
	4a. Facility Name (If not institution, give street and number) Manor Care Chevy Chase					4b. City, Town, or Location of Death Chevy Chase		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 023-03-0764	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 13, 1910		9. Birthplace (State or Foreign Country) Boston, Mass.	
	Usual Residence of Decedent								
10e. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 7417 LynnHurst Street					10f. Zip Code 20815		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Housewife		
17. Father's Name (First, Middle, Last) Harrie Ira Brett					18. Mother's Name (First, Middle, Maiden Surname) Urma Webster				
19e. Informant's Name/Relationship (Type, Print) Robert Brett Bronaugh					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7417 Lynnhurst Street, Chevy Chase, Md. 20815				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven		Date 3/7/2000		20c. Location - City or Town, State Silver Spring, Md.		
21. Signature of Funeral Service Licensee Thomas E. Donabaker					22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, DC. 20016				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dementia Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death Years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Ellen Pinholt MD					29c. License number D51015		29d. Date signed (Month, Day, Year) March 6, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellen Pinholt, MD., 5530 Wisconsin Ave. #1045, Chevy Chase, MD. 20815									
31. Date filed (Month, Day, Year) MAR 07 2000			32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09154

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DEWANE FRANKLIN BRYANT				2. Date of Death Month Day Year MARCH 2, 2000		3. Time of Death 16:30		
	4e. Facility Name (If not institution, give street and number) 15720 SENECA ROAD				4b. City, Town, or Location of Death GERMANTOWN		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 217 42 3555		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 16, 1946	9. Birthplace (State or Foreign Country) WEST VIRGINIA	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10e. State MD.	10b. County MONTGOMERY		10c. City, Town or Location GERMANTOWN			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 15720 SENECA ROAD			10f. Zip Code 20874		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1964-1965		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANIC			16b. Kind of Business/Industry AUTOMOTIVE			
17. Father's Name (First, Middle, Last) WINFRED C. BRYANT				18. Mother's Name (First, Middle, Maiden Surname) MAE N. KIRBY					
19a. Informant's Name/Relationship (Type, Print) MAE N. KIRBY, MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15720 SENECA ROAD, GERMANTOWN, MD. 20874					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RESTHAVEN MEMORIAL CEM.		Date 3/7/00		20c. Location - City or Town, State FREDERICK, MD.			
21. Signature of Funeral Service Licensee <i>Muriel H. Barber</i>				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882					
Physician /Medical Examiner	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Coronary artery disease Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____						Approximate Interval Between Onset and Death years years		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Patricia L. Tomsko MD</i>		29c. License number D51916		29d. Date signed (Month, Day, Year) March 2, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852									
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature <i>Bruce B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09155

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Sarah Budlow

2. Date of Death

March 6, 2000

3. Time of Death

11:30pm

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

263-42-8431

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

8. Date of Birth (Month, Day, Year)

December 12, 1906

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6121 Montrose Road

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Itzhak Londer

18. Mother's Name (First, Middle, Maiden Surname)

Elke (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Irene Kaplan/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12310 Oak Creek Lane #911 Fairfax, VA 22033

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Lebanon Cemetery

Date

MAR 9 2000

20c. Location - City or Town, State

Adelphi. MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Stein Hebrew Memorial Funeral H.

232 Carroll St. NW Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

1 WEEK

Due to (or as a consequence of):

b. HYPERTENSIVE CEREBROVASCULAR DISEASE YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 05885

29d. Date signed (Month, Day, Year)

03/07/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE, MD

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

4

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it sets out the policy of the new administration. The President states that he is a firm believer in the principles of liberty and justice for all, and that he is determined to uphold these principles in the face of the opposition of the Southern States. He also states that he is determined to maintain the Union, and that he will use all the powers of the Executive to do so. The letter is a very eloquent and powerful statement of the President's policy, and it is a document of great historical importance.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1861. It is a very important document, as it sets out the financial policy of the new administration. The Secretary states that the Government is in a sound financial position, and that he is determined to maintain this position in the face of the opposition of the Southern States. He also states that he is determined to maintain the Union, and that he will use all the powers of the Executive to do so. The report is a very eloquent and powerful statement of the Secretary's policy, and it is a document of great historical importance.

3. The third part of the document is a report from the Secretary of the Interior, dated January 1, 1861. It is a very important document, as it sets out the policy of the new administration regarding the management of the public lands. The Secretary states that the Government is in a sound financial position, and that he is determined to maintain this position in the face of the opposition of the Southern States. He also states that he is determined to maintain the Union, and that he will use all the powers of the Executive to do so. The report is a very eloquent and powerful statement of the Secretary's policy, and it is a document of great historical importance.

4. The fourth part of the document is a report from the Secretary of the War, dated January 1, 1861. It is a very important document, as it sets out the policy of the new administration regarding the management of the military. The Secretary states that the Government is in a sound financial position, and that he is determined to maintain this position in the face of the opposition of the Southern States. He also states that he is determined to maintain the Union, and that he will use all the powers of the Executive to do so. The report is a very eloquent and powerful statement of the Secretary's policy, and it is a document of great historical importance.

5. The fifth part of the document is a report from the Secretary of the Navy, dated January 1, 1861. It is a very important document, as it sets out the policy of the new administration regarding the management of the navy. The Secretary states that the Government is in a sound financial position, and that he is determined to maintain this position in the face of the opposition of the Southern States. He also states that he is determined to maintain the Union, and that he will use all the powers of the Executive to do so. The report is a very eloquent and powerful statement of the Secretary's policy, and it is a document of great historical importance.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09156

Certificate of Death

Reg. No.

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

Mary-Anne Callanan

2. Date of Death

Month Day Year
March 4, 2000

3. Time of Death

5:00PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

307-28-5951

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 4, 1923

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9706 Corkran Lane

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Technologist

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Sherman Minton

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Gurtz

19a. Informant's Name/Relationship (Type, Print)

John H. Callanan/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9706 Corkran Lane, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Mar. 6,

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

[Signature] M00803

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO PULMONARY ARREST

Due to (or as a consequence of):

b. MULTI SYSTEM ORGAN FAILURE

Due to (or as a consequence of):

c. TOXIC SHOCK SYNDROME

Due to (or as a consequence of):

d. STAPHYLOCOCCAL SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MYO CARDIAC DYSFUNCTION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

00052774

29d. Date signed (Month, Day, Year)

3/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEO C. ROTUNDO SUBURBAN 1405 PLAZA BETHESDA MD

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

[Signature] B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09157

Amend #6, 3/6/2000, BMW, Montg. Co

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carmen S. Castellanos				2. Date of Death Month Day Year March 3, 2000		3. Time of Death 5:05 pm		
	4a. Facility Name (If not institution, give street and number) 10920 Connecticut Avenue #315				4b. City, Town, or Location of Death Kensington		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-68-0982	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 5, 1922		9. Birthplace (State or Foreign Country) Colombia	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Kensington		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 10920 Connecticut Avenue #315				10f. Zip Code 20895		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Colombian		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Jacobo Senior				18. Mother's Name (First, Middle, Maiden Surname) Antonia Marino					
19a. Informant's Name/Relationship (Type, Print) Myriam S. Lemmerman (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10905 Troy Road Rockville, Maryland 20852					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 2000 Alexandria, Virginia			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's Disease Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 5 yrs.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28e. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D 32417		29d. Date signed (Month, Day, Year) March 4, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rahul Gilotra, M.D. 12016 Georgia Avenue Wheaton, MD 20902									
31. Date filed (Month, Day, Year) MAR 06 2000				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09158

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Ruth Chilcote

2. Date of Death

March 1, 2000 Year

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

8908 Columbine Lane

4b. City, Town, or Location of Death

Upper Marlboro

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

343-12-5848

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 19, 1919

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

8908 Columbine Lane

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Shipping clerk

16b. Kind of Business/Industry

Shoe Manufacturer

17. Father's Name (First, Middle, Last)

Breck Leach

18. Mother's Name (First, Middle, Maiden Surname)

Edna Pleasant

19a. Informant's Name/Relationship (Type, Print)

Paul Michael Chilcote - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8908 Columbine Lane, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Robinson New Cemetery

Date

March 6
2000

20c. Location - City or Town, State

Robinson, IL

21. Signature of Funeral Service Licensee

R.W. Robinson

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.
5517 Vine Street, Alexandria, VA 22310-102523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Ovarian Cancer

Approximate
Interval Between
Onset and Death

1 Year

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Harvey Katzen

29c. License number

D-17605

29d. Date signed (Month, Day, Year)

March 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harvey Katzen, MD 8926 Woodburn Rd. Clinton, Maryland

State
Registrar

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

b permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09159

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MIREILLE CITRISTENSEN		2. Date of Death Month Day Year March 6 2000		3. Time of Death 8:30 AM
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 579-48-4615	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) April 9, 1924		9. Birthplace (State or Foreign Country) France		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Montgomery
	10c. City, Town or Location Rockville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 12914 Penrose Street		10f. Zip Code 20853		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Robert Boulanger		18. Mother's Name (First, Middle, Maiden Surname) Hermine Plouton		
	19e. Informant's Name/Relationship (Type, Print) Jose J. Christensen/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12818 Weiss Street, Rockville, Maryland 20853		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State Rockville, Maryland
	21. Signature of Funeral Service Licensee M. H. S. Higgins M00846		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805		
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Asthma				Approximate Interval Between Onset and Death years
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Partial left pneumothorax, pelvic mass				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 29453			
29b. Signature and title of certifier Alan S. Chanals MD		29d. Date signed (Month, Day, Year) March 6 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANAN CITANACES 15215 Shady Grove Rd Rockville Md 20850					
31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature Beverly B. Sparks			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09160

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH JANE CORDEL				2. Date of Death Month Day Year March 3, 2000		3. Time of Death 6:45am	
	4a. Facility Name (If not institution, give street and number) Montgomery Village Nursing & Rehab. Center				4b. City, Town, or Location of Death Montgomery Village		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-26-9953		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 24, 1927	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Germantown	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 11701 Shakespeare Boulevard		10f. Zip Code 20876		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Delaney Best				18. Mother's Name (First, Middle, Maiden Surname) Mary Best			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Raymond C. Cordel (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11701 Shakespeare Blvd., Germantown, MD 20876			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		20c. Location - City or Town, State Cheltenham, Maryland		20d. Date 3/8/00	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Robert G. DeVol				22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death WEEKS YEARS
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Gabriel A. Berrebi M.D.				29c. License number B30692		29d. Date signed (Month, Day, Year) March 3, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Gabriel A. Berrebi M.D. 15225 Shady Grove Rd. #305 Rockville, Md. 20852							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) MAR 08 2000				32. Registrar's Signature B. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09161

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD A. CROMES

2. Date of Death

March 4, 2000

3. Time of Death

5:00 a.m.

4a. Facility Name (If not institution, give street and number)

2106 Gatewood Place

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

261-74-6761

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 1, 1943

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2106 Gatewood Place

10f. Zip Code

20903

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1962-67

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

Grover Cromes

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Tillman

19a. Informant's Name/Relationship (Type, Print)

Janet P. Cromes - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2106 Gatewood Place, Silver Spring, MD 20903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

gate of Heaven Cemetery

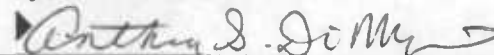
Date

3-10-00

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.

11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Aortic Stenosis

Due to (or as a consequence of):

c. Subacute Bacterial Endocarditis

Due to (or as a consequence of):

d. Diabetes Mellitis

Approximate Interval Between Onset and Death

12 hr.

56 years

2 months

11 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fatty Hepatosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

XX ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

XX ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

XX ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

XX ☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D08832

29d. Date signed (Month, Day, Year)

March 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Max G. Sherer, M.D., 800 Pershing Drive, Silver Spring, Maryland 20910

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09162

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Earl Francis Carrick

2. Date of Death

March 7 2000

3. Time of Death

1845

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

215-26-3493

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 20, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne's

10c. City, Town or Location

Queenstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

120 Bryans Channel Way

10f. Zip Code

21658

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Lumber Industry

17. Father's Name (First, Middle, Last)

Walter Benjamin Carrick

18. Mother's Name (First, Middle, Maiden Summa)

Blanche E. Coale

19a. Informant's Name/Relationship (Type, Print)

Wayne Carrick/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 660, Millington, Maryland 21651

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crumpton Cemetery

Date

2/10/2000 Crumpton, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
370 W. Cypress Street, Millington, Maryland 21651

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

< 30 min.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive heart failure

Due to (or as a consequence of):

> 3 yrs.

c. Constrictive pericarditis (dynamic ~ 55 yrs.

Due to (or as a consequence of):

d. obstruction of ventricular outflow tract

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☒ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D10938

29d. Date signed (Month, Day, Year)

March 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Trever, 7696 Ocean Gateway, Easton, Maryland 21601

31. Date filed (Month, Day, Year)

MAR 10 2000

32. Registrar's Signature

State
Registrar

Earl Carrick

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

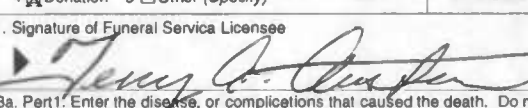
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 09163**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUSSELL DAVIS				2. Date of Death Month MARCH Day 5 Year 2000				3. Time of Death 11:45PM										
	4a. Facility Name (If not Institution, give street and number) FT. WASHINGTON HOSPITAL				4b. City, Town, or Location of Death FT. WASHINGTON P.G				4c. County of Death										
Funeral Director	5. Social Security Number 577-07-7873		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 21, 1913		9. Birthplace (State or Foreign Country) WASH., D.C.										
	Usual Residence of Decedent																		
10a. State VA		10b. County FAIRFAX		10c. City, Town or Location FALLS CHURCH				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
10e. Street and Number 2287 IDYLWOOD STATION LN.				10f. Zip Code 22043				10g. Citizen of What Country? USA											
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER				16b. Kind of Business/Industry WASHINGTON GAS											
17. Father's Name (First, Middle, Last) JESSE DAVIS					18. Mother's Name (First, Middle, Maiden Surname) KATIE DEPOY														
19a. Informant's Name/Relationship (Type, Print) JANE MARDEN (DAUGHTER)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2287 IDYLWOOD STATION LN, FALLS CHURCH, VA.														
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) SCH. GEORGETOWN MEDICAL		Date 3/5/00		20c. Location - City or Town, State WASHINGTON, D.C.												
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W. WASH, DC. 20011														
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Cerebrovascular Accident</td> <td rowspan="4"> Approximate Interval Between Onset and Death 2 d yes 2 d </td> </tr> <tr> <td>b.</td> <td>Parkinson</td> </tr> <tr> <td>c.</td> <td>Ventricular Arrhythmia</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Cerebrovascular Accident	Approximate Interval Between Onset and Death 2 d yes 2 d	b.	Parkinson	c.	Ventricular Arrhythmia	d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Cerebrovascular Accident	Approximate Interval Between Onset and Death 2 d yes 2 d																
	b.	Parkinson																	
	c.	Ventricular Arrhythmia																	
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred										
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 				29c. License number 045365		29d. Date signed (Month, Day, Year) 17 April, 6-2000										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Sidores 11711 LIVINGSTON RD, FT. WASHINGTON, MD. 20744																			
31. Date filed (Month, Day, Year) MAR 10 2000			32. Registrar's Signature 																

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural," or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deleted for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09164

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas M. Davis, Jr.

2. Date of Death
Month Day Year

March 7 2000

3. Time of Death

10:00 pm

4a. Facility Name (If not institution, give street and number)

11211 Mitscher Street

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-26-5532

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 17, 1926

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11211 Mitscher Street

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Date: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Commercial Real Estate

17. Father's Name (First, Middle, Last)

Thomas M. Davis, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Annie Mae Rhyne

19a. Informant's Name/Relationship (Type, Print)

Donald W. Davis / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11211 Mitscher St., Kensington, MD 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

3/10/00

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Coronary Artery Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

b.

Congestive Heart Failure

Due to (or as a consequence of):

6 weeks

c.

Chronic obstructive Pulmonary Disease

Due to (or as a consequence of):

years

d.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

044157

29d. Date signed (Month, Day, Year)

March 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRA BERGER M.O. 809 Vears mill Road, Pockville, Maryland. 20851

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

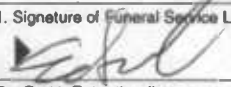


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09165

Certificate of Death

Reg. No.

Amend #7,3/6/2000,EMW, Montg. Co.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JEROME DAVIDSON				2. Date of Death Month Day Year FEB. 25, 2000		3. Time of Death 9:45 PM	
	4a. Facility Name (If not institution, give street and number) MARINER HEALTH CARE				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 115.12.9765	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05.17.1915		9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location WHEATON		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 4051 ADAMS DRIVE				10f. Zip Code 20902-2357		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRANSPORTATION SPECIALIST		16b. Kind of Business/Industry INTERSTATE COMMERCE COMMISSION		
17. Father's Name (First, Middle, Last) SIGMUND DAVIDSON				18. Mother's Name (First, Middle, Maiden Surname) JULIA KAISER				
19a. Informant's Name/Relationship (Type, Print) IRENE DAVIDSON WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4051 ADAMS DRIVE, WHEATON, MARYLAND 20902-2357				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. COMFORT CREMATORY		Date 2.29.2000		20c. Location - City or Town, State ALEXANDRIA, VA		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EDEMA Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 2 WEEKS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DISPHAGIA, PERCUTANEOUS GASTROSTOMY, DEMENTIA						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number DO2338		29d. Date signed (Month, Day, Year) FEB. 29, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. RICHARD P. DELANEY, MD 3929 FERRARA DRIVE, WHEATON, MARYLAND 20906								
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09166

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Harilaos Demogiorgas				2. Date of Death Month Day Year 3 5 2000		3. Time of Death 9 40/pm		
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 212-64-0798		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) March 17, 1932		
	9. Birthplace (State or Foreign Country) Greece		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Wheaton		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 11604 Newport Mill Road		10f. Zip Code 20902		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed		16b. Kind of Business/Industry Restaurant					
17. Father's Name (First, Middle, Last) Harilaos Demogiorgos				18. Mother's Name (First, Middle, Maiden Surname) Georgia Kazakos					
19a. Informant's Name/Relationship (Type, Print) Panagiota Demogiorgos / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11604 Newport Mill Road, Wheaton, Maryland 20902					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Date 03/08/00		20d. Location - City or Town, State Silver Spring, Maryland			
21. Signature of Funeral Service Licensee				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Intra Cerebral Hemorrhage</u> Due to (or as a consequence of): b. <u>Hypertension</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>neurologic</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <u>[Signature]</u>	
		29c. License number 016495		29d. Date signed (Month, Day, Year) 3/6/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joel Goozh MD 4701 RANDOLPH RD Rockville MD 20852									
State Registrar		31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature <u>[Signature]</u>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09167

Amend #17, 3/6/2000, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Dickens				2. Date of Death Month Day Year February 27, 2000		3. Time of Death 8:00 PM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 212-13-0641	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 6, 1932		9. Birthplace (State or Foreign Country) Ghana
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10a. Street and Number 13915 Castle Blvd. #11				10f. Zip Code 20904		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home maker			16b. Kind of Business/Industry Home	
17. Father's Name (First, Middle, Last) Paa (unavailable) Enkson				18. Mother's Name (First, Middle, Maiden Surname) Agnes Prah				
19a. Informant's Name/Relationship (Type, Print) Clara Bullock - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3018 Button Bush Lane, Laurel, MD 20724				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, MD		Date 3/31/00
21. Signature of Funeral Service Licensee				22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Adenocarcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Antonio G. Lyons				29c. License number D15146		29d. Date signed (Month, Day, Year) 2/29/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Antonio G. Lyons 354 University Blvd W. Silver Spring MD 20901								
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09168

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOTTIE SHRIEVES DAVIS				2. Date of Death Month Day Year MARCH 4, 2000		3. Time of Death 12:45 AM	
	4a. Facility Name (If not institution, give street and number) SALISBURY CENTER; GENESIS ELDERCARE				4b. City, Town, or Location of Death SALISBURY, MD		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 220-12-1440	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1/24/06		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State MD		10b. County Worcester		10c. City, Town or Location Pocomoke City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 614 Clarke Ave.				10f. Zip Code 21851		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Domestic	
17. Father's Name (First, Middle, Last) William Thomas Shrieves				18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Truitt				
19a. Informant's Name/Relationship (Type, Print) Thorbourne Davis/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 352 Carey Ave., Salisbury, MD 21804				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Nelson's Cemetery		Date 3/7/00		20c. Location - City or Town, State Pocomoke City, MD		
21. Signature of Funeral Service Licensee Michael A Dean MO1129				22. Name and Address of Facility Holloway Nelson Funeral Home, P.A. 103 Linden Av. Pocomoke City, MD 21851				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. Cerebrovascular disease Due to (or as a consequence of):						Approximate Interval Between Onset and Death yes. yes.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Heart failure Due to (or as a consequence of):						
		c. _____ Due to (or as a consequence of):						
		d. _____ Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]						
		29c. License number D-39813			29d. Date signed (Month, Day, Year) 3/6/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804								
31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09169

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Helen Parezo Dukes</i>				2. Date of Death Month Day Year <i>MARCH 8 2000</i>		3. Time of Death <i>0400</i>	
	4a. Facility Name (If not institution, give street and number) <i>PENINSULA REGIONAL MEDICAL CENTER</i>				4b. City, Town, or Location of Death <i>SALISBURY</i>		4c. County of Death <i>WICOMICO</i>	
Funeral Director	5. Social Security Number <i>094-01-2344</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>85</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Sept. 25, 1914</i>		9. Birthplace (State or Foreign Country) <i>New York</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Virginia</i>	10b. County <i>Accomack</i>	10c. City, Town or Location <i>Chincoteague</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>6229 Ocean Blvd.</i>			10f. Zip Code <i>23336</i>		10g. Citizen of What Country? <i>U. S. A.</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Self</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Charles Parezo</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Carrie Skanrup</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>John T. Dukes, Jr. Husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6229 Ocean Blvd. Chincoteague, Virginia 23336</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Downing Cemetery</i>		Date <i>3-11-00</i>		20c. Location - City or Town, State <i>Oak Hall, Virginia</i>	
	21. Signature of Funeral Service Licensee <i>Constantine Bailey</i>		22. Name and Address of Facility <i>Salyer Funeral Home Chincoteague, Virginia 23336</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Pneumonia, Bilateral</i> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i> <i>Parkinsons Disease</i> <i>Hypokalemia</i>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
State Registrar	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
6	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>827670</i>		29d. Date signed (Month, Day, Year) <i>3/8/2000</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. L. M. Evangelista</i>		<i>105 Pine Bluff Road #4 Salisbury, MD 21801</i>					
31. Date filed (Month, Day, Year) <i>MAR 09 2000</i>		32. Registrar's Signature <i>[Signature]</i>						

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State of Maryland / Department of Health and Mental Hygiene 00 09170

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lucy Lee Donahue				2. Date of Death Month Day Year March 6, 2000		3. Time of Death 7:58 p.m.	
	4a. Facility Name (If not institution, give street and number) 223 Marina Lane (Residence)				4b. City, Town, or Location of Death Church Hill		4c. County of Death Queen Anne's	
Funeral Director	5. Social Security Number 229-07-6037		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 30, 1910	
	9. Birthplace (State or Foreign Country) Virginia							
Usual Residence of Decedent								
10a. State Maryland		10b. County Queen Anne's		10c. City, Town or Location Church Hill			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. Street and Number 223 Marina Lane				10f. Zip Code 21623		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home		
17. Father's Name (First, Middle, Last) Ernest Lee				18. Mother's Name (First, Middle, Maiden Surname) Josephine Hale				
19a. Informant's Name/Relationship (Type, Print) Philip Donahue/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Marina Lane, Church Hill, MD 21623				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC 3/7/2000		20c. Location - City or Town, State Stevensville, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>circulatory system accident</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <u>1 week</u> Due to (or as a consequence of): c. <u></u> Due to (or as a consequence of): d. <u></u>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number 17-0013824		29d. Date signed (Month, Day, Year) 3-7-00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Seymour, 122 Speer Road, Chestertown, Maryland 21620								
31. Date filed (Month, Day, Year) MAR 07 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09171

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry

Ewald

2. Date of Death

MARCH 01, 2000

3. Time of Death

UNKNOWN

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4601 North Park Ave. # 903

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

578-36-9562

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sep. 23, 1930

9. Birthplace (State or Foreign Country)

Mobile, Al.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

☒ Yes 2 ☐ No

10a. Street and Number

4601 North Park Ave. # 903

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1952-195713. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Government Printing Office

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Henry Philip Ewald

18. Mother's Name (First, Middle, Maiden Surname)

Annie Laurie Greene

19a. Informant's Name/Relationship (Type, Print)

Michael Richwine - Executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1501 Pennsylvania Ave. NW., Washington, D.C.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rock Creek Cemetery

Date

3/10/00 Washington, D.C.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Thomas E. Deenbaker

22. Name and Address of Facility Joseph Gawler's Sons, Inc.

5130 Wisc. Ave. NW., Washington, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Cardiac Arrest

Due to (or as a consequence of):

b.

Atherosclerotic Heart Disease

Due to (or as a consequence of):

c.

Diabetes Mellitus

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

acute

10 yrs

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lumbar Curvature

Portal Hypertension

Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident
3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frank J. Fedor MD

29c. License number

DC. 1874

29d. Date signed (Month, Day, Year)

3/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank J. Fedor, MD., 4201 Cathedral Ave. NW., Washington, D.C. 20016-4901

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09172

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Claire Farber				2. Date of Death Month Day Year March 5, 2000		3. Time of Death 2:29 P.M.																																								
	4a. Facility Name (If not institution, give street and number) 19310 Club House Road, Apt. 407				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery																																								
Funeral Director	5. Social Security Number 063-20-4642		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 99 Yrs.	8. Date of Birth (Month, Day, Year) January 1, 1901	9. Birthplace (State or Foreign Country) Russia																																									
	Usual Residence of Decedent				10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																										
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg		10d. Inside City Limits																																								
	10e. Street and Number 19310 Club House Road, Apt. 407				10f. Zip Code 20886		10g. Citizen of What Country? U.S.A.																																								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																																								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fashion Designer		16b. Kind of Business/Industry Garment																																										
	17. Father's Name (First, Middle, Last) Joseph McKible				18. Mother's Name (First, Middle, Maiden Surname) Eva Goldstein																																										
	19a. Informant's Name/Relationship (Type, Print) Hillary Blackton/Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19008 High Point Drive, Gaithersburg, MD, 20879																																										
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Geo. Wash. University Medical Center		Date March 5, 2000		20c. Location - City or Town, State Washington, D.C.																																								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007, Washington, D.C. 20037																																										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																														
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. STROKE</td> <td rowspan="4">Approximate Interval Between Onset and Death DAYS</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">b. CEREBROVASCULAR DISEASE</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c. </td> <td rowspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">d. </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. STROKE						Approximate Interval Between Onset and Death DAYS	Due to (or as a consequence of):						Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CEREBROVASCULAR DISEASE						Due to (or as a consequence of):						c.						Due to (or as a consequence of):	d.				
Immediate Cause (Final disease or condition resulting in death)	a. STROKE						Approximate Interval Between Onset and Death DAYS																																								
	Due to (or as a consequence of):																																														
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		Due to (or as a consequence of):																																													
c.						Due to (or as a consequence of):																																									
d.																																															
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, TYPE 2 ALZHEIMER'S DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																																								
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																								
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																												
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																																										
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																																												
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																														
	29b. Signature and title of certifier 				29c. License number D09764		29d. Date signed (Month, Day, Year) MARCH 6, 2000																																								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN A. BRISKIN MD 15215 SHADY GROVE RD, #303, ROCKVILLE MD 20850																																														
State Registrar	31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature 																																												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09173

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDGAR

M.

FRALEY

2. Date of Death

MARCH 1, 2000

3. Time of Death

13:40

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

213-56-9139

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 29 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9505 Melrose Square Way

10f. Zip Code

20882

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Vietnam13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Lock Smith

16b. Kind of Business/Industry

Lock Service

17. Father's Name (First, Middle, Last)

Marion L. Fraley

18. Mother's Name (First, Middle, Maiden Surname)

Audrey E. Howes

19a. Informant's Name/Relationship (Type, Print)

Lynne C. Fraley / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9505 Melrose Square Way, Gaithersburg, Md. 20882

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

3/2/00

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

Muriel H. Barber Funeral Home
P.O. Box 5038, Laytonsville, Maryland 2088223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. GLIOBLASTOMA MULTIFORME

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 MONTHS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Joseph Michael Haggerty MD

29c. License number

D32407

29d. Date signed (Month, Day, Year)

MARCH 02, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH MICHAEL HAGGERTY MD 9707 MEDICAL CTR DR ROCKVILLE, MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09174

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia A. Fritter				2. Date of Death Month Day Year March 2, 2000		3. Time of Death 8:30 PM	
	4a. Facility Name (If not institution, give street and number) LORION MUSTI SPECIALTY UNIT				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 579-20-7306		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Oct 12, 1929	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County St. Marys		10c. City, Town or Location Avenue	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 20930 Olen Mattingly Rd		10f. Zip Code 20609		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Gift Shop			
	17. Father's Name (First, Middle, Last) Charles McCarthy				18. Mother's Name (First, Middle, Maiden Surname) Helen Thompson			
	19a. Informant's Name/Relationship (Type, Print) Mark Duhamel/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5424 Harris Farm Ln, Clarksville, MD 21029			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Date Mar 6		20d. Location - City or Town, State Brentwood, MD	
	21. Signature of Funeral Service Licensee Alan J. Donnell				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. METASTATIC LUNG CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 6 WEEKS 3 MONTHS							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MALNUTRITION CHRONIC OBSTRUCTIVE PULMONARY DISEASE							
	23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> NO								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> NO								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> NO		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier David O. Nantson				29c. License number D36974		29d. Date signed (Month, Day, Year) MAR 3, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID O. NANTSON				10724 LITTLE PATIENT PARKWAY COLUMBIA MD 21044				
31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature Benita B. Sparks						

ORIGINAL

Amended #5, WCHD, none State of Maryland / Department of Health and Mental Hygiene
amend item 23a, 27, per me G782 4/13/00 yg 3/6/00 epw
per G. Price

Certificate of Death

Reg. No.

00 09175

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLIE DANIEL FOWLER				2. Date of Death Month Day Year FEBRUARY 29, 2000		3. Time of Death 10:10 AM.	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death OCEAN CITY		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 900-25-7380		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 36		8. Date of Birth (Month, Day, Year) 2-22-2000	
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County WORCESTER		10c. City, Town or Location OCEAN CITY	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 164 CLAMSHELL		10f. Zip Code 21842		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (14 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AT HOME		16b. Kind of Business/Industry OWN HOME				
17. Father's Name (First, Middle, Last) DAVID MATTHEW FOWLER				18. Mother's Name (First, Middle, Maiden Surname) JUDI R. LITTLE				
19a. Informant's Name/Relationship (Type, Print) DAVID M. FOWLER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 164 CLAMSHELL OCEAN CITY, MD. 21842				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF THE PINES		Date 3-3		20c. Location - City or Town, State BERLIN, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. 21811				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DISSEMINATED HERPES INFECTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 1, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09176

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bertie (nmn) Fuller

2. Date of Death

Month Day Year
MARCH 07, 2000

3. Time of Death

7:10 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Berlin Nursing and Rehabilitation Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

220-18-9798

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

106

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb. 9, 1894

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

8903 E. Biscayne Dr.,

10f. Zip Code

21842

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Supervisor

16b. Kind of Business/Industry

Manufacturing Co.

17. Father's Name (First, Middle, Last)

Charles Hare

18. Mother's Name (First, Middle, Maiden Summa)

Frances (unknown)

19a. Informant's Name/Relationship (Type, Print)

Ethel H. Hilbert

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8903 E. Biscayne Dr., Ocean City, Md. 21842

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

3-13-00

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home

108 William St., Berlin, Md. 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anterior descending Vascular Disease gen

Due to (or as a consequence of):

b. ag

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

3-8-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD. 21811 410-641-4400

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

FULLER, BERTIE
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09177.

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Robert L. Fogwell, Jr.

2. Date of Death

March 8, 2000

3. Time of Death

6:50 p.m.

4a. Facility Name (If not institution, give street and number)

Magnolia Hall Nursing Home

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

5. Social Security Number

218-16-5806

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 28, 1916

9. Birthplace (State or Foreign Country)

Galena, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne's

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

300 Princess Anne Drive

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farming

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Robert L. Fogwell

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Ford

19a. Informant's Name/Relationship (Type, Print)

Sarah D. Fogwell/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

300 Princess Anne Drive, Chestertown, MD 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Galena Cemetery

Date

3/11/2000

20c. Location - City or Town, State

Galena, Maryland

21. Signature of Funeral Service Licensee

Sarah D. Fogwell

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
370 W. Cypress Street, Millington, Maryland 2165123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Pneumonia*
Due to (or as a consequence of):b. *Advanced Sementia*
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

4 day

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

KW

24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

LLH/M... MD.

29c. License number

D21313

29d. Date signed (Month, Day, Year)

3/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIN K. WUN - 223 High St., Chestertown, MD 21620

31. Date filed (Month, Day, Year)

MAR 10 2000

32. Registrar's Signature

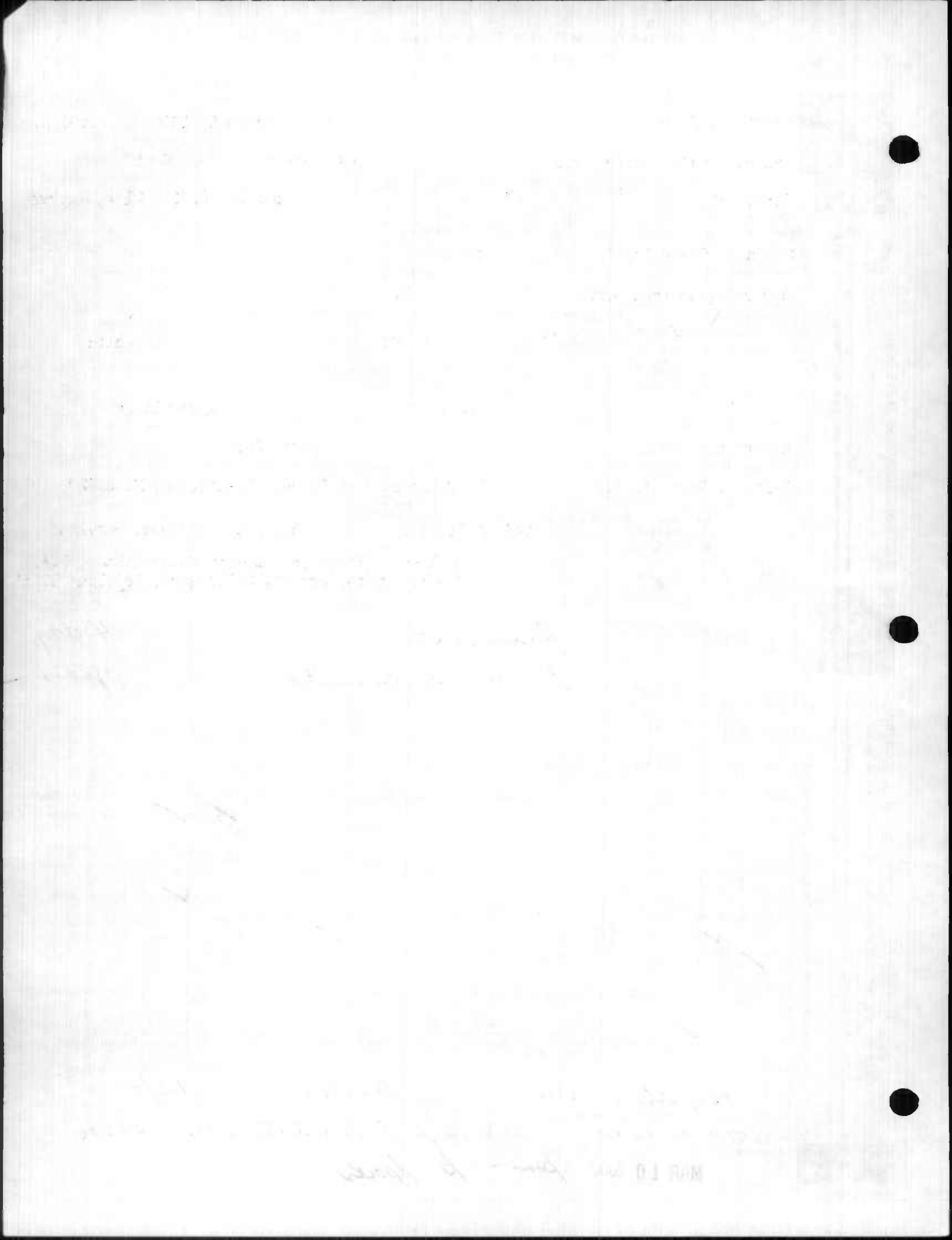
*Benjamin S. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09178

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ida Garelick				2. Date of Death Month Day Year March 5th 2000		3. Time of Death 9 45 pm	
	4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 157-12-0024		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 27, 1919	
	9. Birthplace (State or Foreign Country) California		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 6121 Montrose Rd.		10f. Zip Code 20852	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Barney Tuchman	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Dora Weintraum				19a. Informant's Name/Relationship (Type, Print) Marsha Friedman/ daughter			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78 Salem Rd., Washington Township, NJ 07675				20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Moriah Cemetery				20c. Location - City or Town, State Fairview, NJ		21. Signature of Funeral Service Licensee Donald C. Stettin	
	22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. acute cardio-pulmonary arrest Due to (or as a consequence of): b. coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dysphagia osteoporosis hypothyroidism Aspiration Pneumonia protein Calorie Malnutrition Chronic cerebral ischemia				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was cause referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Consuelo Martinez			
	29c. License number D:44907				29d. Date signed (Month, Day, Year) March 6th 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Road Rockville MD 20852				31. Data filed (Month, Day, Year) MAR 07 2000			
	32. Registrar's Signature P. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09179

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) AMELIA (NMN) GEHANDER				2. Date of Death Month Day Year MARCH 07 2000		3. Time of Death 7:40 AM	
4a. Facility Name (If not institution, give street and number) National Institutes of Health				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
5. Social Security Number 462-46-9135		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 15, 1934	
9. Birthplace (State or Foreign Country) Mart, TX							
Usual Residence of Decedent							
10a. State NJ		10b. County Somerset		10c. City, Town or Location Franklin Park		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 77 Amethyst Way				10f. Zip Code 08823		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cosmetic Consultant		16b. Kind of Business/Industry Mary Kay Cosmetics	
17. Father's Name (First, Middle, Last) Milton Sosa				18. Mother's Name (First, Middle, Maiden Surname) Cruz Sanchez			
19a. Informant's Name/Relationship (Type, Print) Carl Gehander (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 77 Amethyst Way Franklin Park, NJ 08823			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Somerset Hills		Data 3/10/00		20c. Location - City or Town, State Basking Ridge, NJ	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Capitol Funeral Service, Inc. 7211 Lee Highway Falls Church, VA 22046			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Renal Failure Due to (or as a consequence of): c. Aplastic Anemia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 4d 3wk 4mos.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Septic Shock, shock liver, thrombocytopenia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number D005 4450		29d. Date signed (Month, Day, Year) 3/7/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Jison 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892							
31. Date filed (Month, Day, Year) MAR 09 2000				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09180

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAUL GOSTKOV				2. Date of Death Month Day Year FEB. 29, 2000				3. Time of Death 10:30 AM		
	4a. Facility Name (If not institution, give street and number) 4701 WILLARD AVENUE APT#524				4b. City, Town, or Location of Death CHEVY CHASE				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 077-22-5635		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 16, 1909		9. Birthplace (State or Foreign Country) POLAND		
	Usual Residence of Decedent										
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location CHEVY CHASE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 4701 WILLARD AVENUE APT#524				10f. Zip Code 20815		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLOTHING				16b. Kind of Business/Industry RETAIL			
17. Father's Name (First, Middle, Last) DAVID GOSTKOV				18. Mother's Name (First, Middle, Maiden Surname) RUSHKIE "UNKNOWN"							
19a. Informant's Name/Relationship (Type, Print) GERRY SIGAL/SON IN LAW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2909 44th ST, NW, WASHINGTON, DC 20016							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GDNS		Date MARCH 2, 2000		20c. Location - City or Town, State FALLS CHURCH, VA					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <u>CARDIAC ARREST</u> Due to (or as a consequence of): b. <u>ALZHEIMER'S DISEASE</u> Due to (or as a consequence of): c. <u>CORONARY ARTERY DISEASE</u> Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number DC7110		29d. Date signed (Month, Day, Year) MARCH 6, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JOEL M. TAUBIN, MD, PC 1145 - 19th STREET, NW, #504, WASHINGTON, DC 20036											
31. Date filed (Month, Day, Year) MAR 07 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09181

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Amalie Gunther Griffith						2. Date of Death Month February Day 27 Year 2000			3. Time of Death 7:00 p.m.	
4a. Facility Name (If not institution, give street and number) Heron Point						4b. City, Town, or Location of Death Chestertown			4c. County of Death Kent	
5. Social Security Number 060-46-0723		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) December 9, 1914
9. Birthplace (State or Foreign Country) New York										
Usual Residence of Decedent										
10a. State Florida		10b. County Indian River		10c. City, Town or Location Vero Beach				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 650 Beach Road						10f. Zip Code 32963		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Richard J. Gunther						18. Mother's Name (First, Middle, Maiden Surname) Amalie Strohmeyer				
19a. Informant's Name/Relationship (Type, Print) Charles Ernest Griffith/Husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 650 Beach Road, Vero Beach, Florida, 32963				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Old Wye Cemetery		Date 3/1/2000		20c. Location - City or Town, State Wye Mills, Maryland		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D0041587		29d. Date signed (Month, Day, Year) 2/28/00				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Helen A. Noble, 122 Speer Road, Chestertown, Maryland 21620										
31. Date filed (Month, Day, Year) FEB 29 2000										
32. Registrar's Signature 										

20

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09182

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rohna O. Hamlett				2. Date of Death Month Day Year March 3, 2000				3. Time of Death 11:00 AM		
	4a. Facility Name (If not institution, give street and number) 13323 Tamworth Ln				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 220-34-2718		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) Dec 31, 1924		9. Birthplace (State or Foreign Country) Jamaica		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 13323 Tamworth Ln		10f. Zip Code 20904		10g. Citizen of What Country? Jamaica			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker	
16b. Kind of Business/Industry War on Poverty		17. Father's Name (First, Middle, Last) William Saunders		18. Mother's Name (First, Middle, Maiden Surname) Isadora Osborne		19a. Informant's Name/Relationship (Type, Print) John L. Hamlett/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13323 Tamworth Ln, Silver Spring, MD 20904			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		20c. Location - City or Town, State Mar 8 Brentwood, MD		21. Signature of Funeral Service Licensee Alan J. Donnell		22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D26571	
29d. Date signed (Month, Day, Year) 3/6/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRVING MIZUS, MD 4930 DELRAY AVE BETHESDA, MD 20814		31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09183

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirley Jane Hanten		2. Date of Death Month March Day 6 Year 2000		3. Time of Death 9:15 AM
	4a. Facility Name (If not institution, give street and number) 7805 Renoir Court		4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 348-20-3552	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) January 5, 1923		9. Birthplace (State or Foreign Country) Illinois		
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 7805 Renoir Court		10f. Zip Code 20854		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Walter Bartlett			18. Mother's Name (First, Middle, Maiden Surname) Helen Henderson		
19a. Informant's Name/Relationship (Type, Print) Kenneth S. Hanten/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7805 Renoir Court, Potomac, Maryland 20854		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		20c. Location - City or Town, State 2000 Arlington, Virginia	
21. Signature of Funeral Service Licensee  M00846		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805			
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease					Years
Due to (or as a consequence of):					
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 0101058258		29d. Date signed (Month, Day, Year) March 7, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyan, M.D., National Naval Medical Center, Bethesda, Maryland 20889					
31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09184

Amend 20b, 3/7/2000, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jennie Vera Heflin

2. Date of Death

Month Day Year
March 3, 2000

3. Time of Death

2:45 AM

4a. Facility Name (If not institution, give street and number)

Manor Care Silver Spring

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

219-64-7296

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 29, 1903

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Chillum

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

833 Cox Avenue

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Alphonso Ciango

18. Mother's Name (First, Middle, Maiden Surname)

Grace Delorenzo

19a. Informant's Name/Relationship (Type, Print)

Francis A. Ciango/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10318 Geranium Ave., Adelphi, MD 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Data

8/3/00

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Stewart D. Stand

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRA CEREBRAL BLEED

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROSIS

Due to (or as a consequence of):

YEARS

c. HYPERTENSION

Due to (or as a consequence of):

YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

Robert T. Maglin, MD

29c. License number

D25422

29d. Date signed (Month, Day, Year)

MARCH 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT T. MAGLIN, MD

13952 BALTIMORE AVE
LAUREL, MARYLAND 20707State
Registrar

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09185

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dana Robin Hill

2. Date of Death

Month Day Year
March 3, 2000

3. Time of Death

7:30AM

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

238-02-3216

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 31, 1955

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18301 Redbridge Court

10f. Zip Code

20832

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Psychologist

16b. Kind of Business/Industry

National Institute
of Health

17. Father's Name (First, Middle, Last)

Arthur Thomas Hill

18. Mother's Name (First, Middle, Maiden Surname)

Lois Loreta Rogers

19a. Informant's Name/Relationship (Type, Print)

See-Yan Lam/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18301 Redbridge Court, Olney, Maryland 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

Mar. 8,

2000

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Dana E. Perry, M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Liver Metastasis

Due to (or as a consequence of):

6 Months

b. Metastatic Breast Cancer

Due to (or as a consequence of):

9 Months

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicida
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Linda M. Burrell, M.D.

29c. License number

D35996

29d. Date signed (Month, Day, Year)

March 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Burrell, M.D. 2101 Medical Park Drive, #210, Silver Spring, MD 20902

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

Barbara B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09186

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles W. Hughes

2. Date of Death
Month Day Year

March 7, 2000

3. Time of Death

11:35 am

4a. Facility Name (If not institution, give street and number)

321 University Blvd., West #132

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

217-44-0528

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 16, 1913

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

321 University Blvd., West #132

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Certified Public Accountant

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Frank J. Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Eva Clingenpeel

19a. Informant's Name/Relationship (Type, Print)

Betty Jean Johnson (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18009 Mill Creek Drive Rockville, Maryland 20855

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

Mar. 8

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Robert E. Ramsey

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicidal 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D37891

29d. Date signed (Month, Day, Year)

March 8 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARAJVANSI MD 121 Congressional Ln # 409 Rockville MD 20852.

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09187

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK ALTON HOLLAND				2. Date of Death Month Day Year 02 29 2000		3. Time of Death 12:45 AM		
	4a. Facility Name (If not institution, give street and number) 3804 Redden Road				4b. City, Town, or Location of Death Pocomoke City		4c. County of Death Worcester		
Funeral Director	5. Social Security Number 220-34-9700		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/05/1912	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Worcester	10c. City, Town or Location Pocomoke City,			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 3804 Redden Road				10f. Zip Code 21851		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer			16b. Kind of Business/Industry Agriculture			
	17. Father's Name (First, Middle, Last) Denard W. Holland				18. Mother's Name (First, Middle, Maiden Surname) Annie Lee Ward				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ruby Richardson/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3724 Redden Rd., Pocomoke City, MD 21851				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Goodwill Meth. Cem.		Data 3/2/00		20c. Location - City or Town, State Pocomoke City, MD		
	21. Signature of Funeral Service Licensee <i>Michael J. Dean</i> M#1129				22. Name and Address of Facility Holloway Melson Funeral Home 103 Linden Ave., Pocomoke City, MD 21851				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Tachycardia / Tachyarrhythmia Due to (or as a consequence of): b. Myofibrillar Due to (or as a consequence of): c. ASCVD Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aneurysm						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pandemic investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>Richard C. Shoemaker</i> MD							
29c. License number A24924		29d. Date signed (Month, Day, Year) 3/1/00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard C. Shoemaker MD									
31. Date filed (Month, Day, Year) MAR 03 2000		32. Registrar's Signature <i>James P. Spence</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09188

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Glean Hamstead

2. Date of Death

Month
3Day
2Year
00

3. Time of Death

1930

4a. Facility Name (If not institution, give street and number)

University of Maryland

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

221-18-3236

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 26, 1930

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Md.

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9800 Coastal Hgwy., #901

10f. Zip Code

21842

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Furniture Gallery

17. Father's Name (First, Middle, Last)

Elmer H. Hamstead

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Moore

19a. Informant's Name/Relationship (Type, Print)

Joyce Hamstead

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9800 Coastal Hgwy., #901, Ocean City, Md. 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Johnstown Cemetery

Date

3-7-00

20c. Location - City or Town, State

Greenwood, Delaware

21. Signature of Funeral Service Licensee

The Burbage Funeral Home

22. Name and Address of Facility

108 William St., Berlin, Md. 21811

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Pneumonia

a. Due to (or as a consequence of):

Idiopathic pulmonary fibrosis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

The Burbage Funeral Home

29c. License number

P11747

29d. Date signed (Month, Day, Year)

3/4/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymond Cross M.D. University of Maryland 22 S. Greene St.
N3E69 Baltimore MD 21201

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

Benjamin B. Smith

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
0000.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09189
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Virginia Handy				2. Date of Death Month Day Year March 1, 2000		3. Time of Death 9:05 PM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare				4b. City, Town, or Location of Death Salisbury, MD		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 215-38-1065		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) AUGUST 23-23 VA.	
	10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury, MD 21804		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 201 Tilghman St.				10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Farm Work	
	17. Father's Name (First, Middle, Last) Robert Tilghman				18. Mother's Name (First, Middle, Maiden Surname) Mary Johnson			
	19a. Informant's Name/Relationship (Type, Print) PAUL HANDY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Tilghman St. Salisbury, MD 21804			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. OLIVE		20c. Location: City or Town, State 3/7/00 Westover, MD			
	21. Signature of Funeral Service Licensee Samuel H. Savage				22. Name and Address of Facility Wharton Funeral Home 22171 Wharton Rd. - Accomac, Va. 2334			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier [Signature]				29c. License number D39815		29d. Date signed (Month, Day, Year) 5/2/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804							
	31. Date filed (Month, Day, Year) MAR 06 2000				32. Registrar's Signature [Signature]			
	State Registrar							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09190

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA. MAY HARDY				2. Date of Death Month Day Year FEBRUARY 26, 2000				3. Time of Death 12:00 MID.	
	4a. Facility Name (If not institution, give street and number) Berlin Nursing-Rehabilitation Ct Berlin, Md.				4b. City, Town, or Location of Death Worcester				4c. County of Death Worcester	
Funeral Director	5. Social Security Number 214-32-0356		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) 9-5-27		9. Birthplace (State or Foreign Country) VA.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County WORCESTER		10c. City, Town or Location POCOMOKE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1830 Sand Pit Rd.				10f. Zip Code 21851		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE				16b. Kind of Business/Industry Private Homes			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) ALFRED Brenney				18. Mother's Name (First, Middle, Maiden Surname) Sarah Collins					
	19a. Informant's Name/Relationship (Type, Print) ALONZO HARDY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1830 Sand Pit Rd. Pocomoke, Md. 21851					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Brenney		20c. Location - City or Town, State 3/4/00 Chincoteague, VA.		20d. Location - City or Town, State Wharton Funeral Home	
	21. Signature of Funeral Service Licensee Samuel G. Savage				22. Name and Address of Facility 22171 Wharton Rd. - Accomac, Va. 23301					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arteriosclerotic Cardiovascular Disease 5 yrs Due to (or as a consequence of):									
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependent Diabetes Mellitus Bilateral Pneumonia. Urosepsis Essential Hypertension Hypothyroidism									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Gregorio M. Belloso MD.				29c. License number D 29505		29d. Date signed (Month, Day, Year) 2-29-2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, MD 5302 CHINABERRY DR., SALISBURY, MD 21801									
	31. Date filed (Month, Day, Year) MAR 06 2000									
State Registrar	32. Registrar's Signature Benjamin B. Smith									

HARDY, ANNA MAY

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09191

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Irby						2. Date of Death Month Day Year February 25, 2000		3. Time of Death 1636		
	4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital, Inc.						4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent		
Funeral Director	5. Social Security Number 217-28-3071		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 7, 1929		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County Queen Annes		10c. City, Town or Location Chestertown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1933 McGennis Road				10f. Zip Code 21620		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) B.T. Tuck						18. Mother's Name (First, Middle, Maiden Surname) Mammie King Tuck Newcomb				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kevin Lee Irby				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 337 High Bridge Rd, Millington, MD. 21651						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center		Date 02/28/00		20c. Location - City or Town, State Stevensville, MD				
	21. Signature of Funeral Service Licensee <i>Jason Fellows</i>				22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home 370 W. Cypress St. Millington, MD. 21651						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <i>Respiratory failure</i> Due to (or as a consequence of): b. <i>possible Pulmonary Emboli</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										15 min
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>9IBlood/Aemia/Aortic Stenosis/Dm Type II</i> <i>HTN/Pcho</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Neil Stoddard MD</i>		29c. License number D 50996		29d. Date signed (Month, Day, Year) 2/26/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Stoddard MD 100 Brown St. Chestertown MD 21620											
State Registrar	31. Date filed (Month, Day, Year) FEB 28 2000		32. Registrar's Signature <i>Geneva B. Sparks</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Feb 18 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09192

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Dorothy Lucille Istvan		2. Date of Death Month March Day 8 Year 2000		3. Time of Death 5:10 p.m.	
4a. Facility Name (If not institution, give street and number) Bayside Care Center		4b. City, Town, or Location of Death Lexington Park		4c. County of Death St. Mary's	
5. Social Security Number 218-30-8140	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 28, 1917
9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent					
10a. State MD	10b. County Charles	10c. City, Town or Location Hughesville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 15475 Scout Camp Road		10f. Zip Code 20637		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) College			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home			
17. Father's Name (First, Middle, Last) Norman Williams			18. Mother's Name (First, Middle, Maiden Surname) Mamie Buckler		
19a. Informant's Name/Relationship (Type, Print) Elizabeth Therres/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15475 Scout Camp Rd. Hughesville, MD. 20637			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		20c. Location - City or Town, State 3/13/00 Bryantown, MD.	
21. Signature of Funeral Service Licensee Daniel C. Echols		22. Name and Address of Facility BRINSFIELD-ECHOLS FUNERAL HOME, P.A. P.O. BOX 128 CHARLOTTE HALL, MD. 20622			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cerebrovascular accident Due to (or as a consequence of): b. Cerebrovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]		29c. License number D19917		29d. Date signed (Month, Day, Year) 3/10/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James E. Boyd, M.D. 23415 Three Notch Rd. California, MD 20619					
31. Date filed (Month, Day, Year) MAR 10 2000		32. Registrar's Signature [Signature]			

State
Registrar

VOID

CERTIFICATE #

00-9193

SEE

CERTIFICATE #

00-3960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09194

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND ALEXANDER JONES

2. Date of Death
Month Day Year
MARCH 5, 20003. Time of Death
16:15 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

none

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb 29, 2000

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

19264 Esmond Terrace

10f. Zip Code

20874

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
0

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

none

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Rudolph Raymond Jones

18. Mother's Name (First, Middle, Maiden Surname)

Melrose George

19a. Informant's Name/Relationship (Type, Print)

Rudolph R. Jones, father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19264 Esmond Terrace, Germantown, MD 20874

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Mar 8,
2000

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Drive, Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Severe Asphyxia

Due to (or as a consequence of):

4 days 20 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Hypoxic Ischemic Encephalopathy

Due to (or as a consequence of):

4 days 20 hrs

c. Seizures

Due to (or as a consequence of):

4 days.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Madhuvigam M.D.

29c. License number

D 43225

29d. Date signed (Month, Day, Year)

March, 05, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MADHU NIGAM, Neonatologist, Shady Grove Adventist Hospital

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

Geneva B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-343-2000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09195

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James W. Kelly

2. Date of Death

March 1, 2000

3. Time of Death

23:07

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577 38 7869

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

Unknown

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1901 Metcrott Road

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unknown

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Starks Kelly

18. Mother's Name (First, Middle, Maiden Surname)

Rosa "Unknown"

19a. Informant's Name/Relationship (Type, Print)

Robert Kelly / brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

718 Nicholson Street NW Washington DC 20011

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Anatomic Gift Foundation

Date

3/3/00

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Anatomic Gift Foundation

13948 Baltimore Avenue Laurel MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asystole.

Due to (or as a consequence of):

b. BRADY Arrhythmia.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 mts.

1.31-00

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal disease

Diabetes.

Peripheral vascular disease.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D19609.

29d. Date signed (Month, Day, Year)

3-2-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. R. Tuli 10810 Barnestown Rd. Gaithersburg, Md. 20878

State
Registrar

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09196

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wilma Ruth Kerr

2. Date of Death

March 5, 2000

3. Time of Death

11:00 pm

4a. Facility Name (If not institution, give street and number)

15020 Westbury Road

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

213-26-5029

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 28, 1928

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15020 Westbury Road

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

William H. Young

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Irene Briscoe

19a. Informant's Name/Relationship (Type, Print)

Edwin L. Kerr, Jr. / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15020 Westbury Road, Rockville, MD 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Carmel Cemetery

Date

3/9/00

20c. Location - City or Town, State

Sunshine, MD

21. Signature of Funeral Service Licensee

Steward S. Stroud

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer

Due to (or as a consequence of):

15 months

b. Brain Metastases

Due to (or as a consequence of):

6 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Benign breast lump

Lung Cancer, 1990

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Linda M. Burrell, MD

29c. License number

D35996

29d. Date signed (Month, Day, Year)

March 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Burrell, MD 2101 Medical Park Drive, #210 Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09197

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harriet J. Kreuzburg				2. Date of Death Month March Day 4 Year 2000		3. Time of Death 12:10 AM		
	4a. Facility Name (If not institution, give street and number) Bedford Court Nursing Home				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 214-03-8136		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Feb 20, 1908		
	9. Birthplace (State or Foreign Country) Connecticut		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 9207 Kingsbury Drive		10f. Zip Code 20910		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Restaurateur		16b. Kind of Business/Industry Food		17. Father's Name (First, Middle, Last) Theodore Judd		18. Mother's Name (First, Middle, Maiden Surname) Rose May Oetzel	
19a. Informant's Name/Relationship (Type, Print) Nancy K. Morton/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 West Nolcrest Drive, Silver Spring, MD		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, VA	
21. Signature of Funeral Service Licensee P. Ryan McMillan		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): Osteomyelitis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death 10 days 1 month			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Amendur		29c. License number D38262		29d. Date signed (Month, Day, Year) March 6, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dramendkuratta 2401 Research BLVD Suite 340 20850		31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09198

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) SYDELL LASKOWITZ				2. Date of Death Month Day Year MARCH 3, 2000		3. Time of Death 9:05 PM	
4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
5. Social Security Number 148.12.4003		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 103 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 2, 1896	
9. Birthplace (State or Foreign Country) RUSSIA		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 6121 MONTROSE ROAD		10f. Zip Code 20852		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) VOLUNTEER		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GENERAL		16b. Kind of Business/Industry GENERAL			
17. Father's Name (First, Middle, Last) JACOB GORLIN				18. Mother's Name (First, Middle, Maiden Surname) FANNIE SHER			
19a. Informant's Name/Relationship (Type, Print) DORIS L. SHAKIN/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 ROSWELL DRIVE, SILVER SPRING, MARYLAND 20901			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING SOLOMON CEMETERY		20c. Date MARCH 6, 2000		20d. Location - City or Town, State CLIFTON, NEW JERSEY	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852			
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ISCHEMIC CARDIOMYOPATHY 10 YEARS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D0018084		29d. Date signed (Month, Day, Year) MARCH 04, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852							
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09199

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SIMON M. LIDERMAN

2. Date of Death

FEB. 29, 2000

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

217.25.7605

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

SEP. 11, 1925

9. Birthplace (State or Foreign Country)

UKRAINE

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1400 FENVICK LANE #914

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ECONOMIST

16b. Kind of Business/Industry

SHIP BUILDING

17. Father's Name (First, Middle, Last)

MOSES LIDERMAN

18. Mother's Name (First, Middle, Maiden Surname)

ENA GOLPRIN

19a. Informant's Name/Relationship (Type, Print)

FELIX S. LIDERMAN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14600 PEBBLE HILL LANE, N. POTOMAC, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

MARCH 6, 2000

20c. Location - City or Town, State

OLENY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive Heart Failure

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Myocardial infarction

1 month

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pulmonary fibrosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OKI KWON, M.D. 1104 Spring street. #201, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09200

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anne W. Loyd					2. Date of Death Month Day Year March 3, 2000			3. Time of Death 11:20 PM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital					4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-46-3064		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) April 29, 1907		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 10000 Brunswick Avenue #329				10f. Zip Code 20902		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yea or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yea 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager				16b. Kind of Business/Industry Bookkeeping			
	17. Father's Name (First, Middle, Last) Powhatan Haines Windish					18. Mother's Name (First, Middle, Maiden Surname) Stella Jones				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert J. Loyd (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8211 18th Avenue Adelphi, Maryland 20783					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date Mar. 7 2000		20c. Location - City or Town, State Brentwood, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901					
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Cerebrovascular Accident Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number D 33224			29d. Date signed (Month, Day, Year) March 4, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ram S. Trehan, M.D. 50 W. Edmonston Drive Rockville, Maryland 20852										
31. Date filed (Month, Day, Year) MAR 09 2000					32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09201

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anne Swain Levis

2. Date of Death

March 6 2000

3. Time of Death

1020

4a. Facility Name (If not institution, give street and number)

Kent & Queen Anne's Hospital

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral
Director

5. Social Security Number

222-16-8502

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

February 4, 1926

9. Birthplace (State or Foreign Country)

Georgetown, DE

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

307 Heron Point

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ralph L. Swain

18. Mother's Name (First, Middle, Maiden Surname)

Elisabeth Mears

19a. Informant's Name/Relationship (Type, Print)

Charles Jackson Levis, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

307 Heron Point, Chestertown, Maryland 21620

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center, LLC 3/7/2000

Date

20c. Location - City or Town, State

Stevensville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Spear Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END-STAGE LIVER DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

b. PRIMARY BILIARY CIRRHOSIS

Due to (or as a consequence of):

>5 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0041587

29d. Date signed (Month, Day, Year)

3/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble 122 Spear Road, Suite 5, Chestertown, Maryland 21620

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09202

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth Lee Mandeville					2. Date of Death Month Day Year March 03 2000		3. Time of Death 9:27 AM		
	4a. Facility Name (If not institution, give street and number) 5212 Nahant Street					4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 265-60-7898		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 3, 1940		9. Birthplace (State or Foreign Country) Greenwich, Conn.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County Montgomery		10c. City, Town or Location Bethesda			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 5212 Nahant Street				10f. Zip Code 20816		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1959-1965		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Locksmith			16b. Kind of Business/Industry Safe masters Company		
	17. Father's Name (First, Middle, Last) Lawrence Mandeville					18. Mother's Name (First, Middle, Maiden Surname) Helen Frances Wood				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary A. Mandeville - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5212 Nahant Street Bethesda, Maryland 20816					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National Cemetery 3-7-00 Quantico, Virginia		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>John F. DeBl</i>				22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Avenue, N.W. Washington, DC 20007					
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Brain Cancer						Approximate Interval Between Onset and Death 14 months			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? no 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Ralph Coan</i>					29c. License number D 01191		29d. Date signed (Month, Day, Year) March 03, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ralph Coan, M.D. 9618 Culver Street Kensington, Md. 20895										
31. Date filed (Month, Day, Year) MAR 08 2000					32. Registrar's Signature <i>B. Sparks</i>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09203

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Mary Catherine Matosian</u>				2. Date of Death Month <u>March</u> Day <u>2</u> Year <u>2000</u>		3. Time of Death <u>4:00 pm</u>		
	4a. Facility Name (If not institution, give street and number) <u>Holy Cross Hospital</u>				4b. City, Town, or Location of Death <u>Silver Spring</u>		4c. County of Death <u>Montgomery</u>		
Funeral Director	5. Social Security Number <u>578-22-6182</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>77</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>May 3, 1922</u>		
	9. Birthplace (State or Foreign Country) <u>Washington, D.C.</u>		10a. State <u>Maryland</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Wheaton</u>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>11816 College View Drive</u>		10f. Zip Code <u>20902</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>1</u> College (1-4 or 5+) <u>1</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>		16b. Kind of Business/Industry <u>Own Home</u>		17. Father's Name (First, Middle, Last) <u>Harry Ware</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Helen Kelly</u>	
19a. Informant's Name/Relationship (Type, Print) <u>Alexander J. Matosian (husband)</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>11816 College View Drive Wheaton, Maryland 20902</u>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metropolitan Crematory</u>		20c. Location - City or Town, State <u>Alexandria, Virginia</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Francis J. Collins Funeral Home, Inc.</u> <u>500 University Blvd., W., Silver Spring, MD 20901</u>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Coronary Myocardopathy</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>b. _____</u> Due to (or as a consequence of): <u>c. _____</u> Due to (or as a consequence of): <u>d. _____</u>		Approximate Interval Between Onset and Death <u>Years</u>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes Mellitus; Cerebrovascular Insufficiency;</u> <u>Multi-Infarct Dementia; Chronic Renal Failure;</u> <u>Biventricular Heart Failure</u>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <u>Mar. 6, 2000</u>		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D 08944</u>		29d. Date signed (Month, Day, Year) <u>March 2, 2000</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Martin C. Shargel, M. D. 3720 Farragut Avenue Kensington, Maryland 20895</u>			
31. Date filed (Month, Day, Year) <u>MAR 06 2000</u>		32. Registrar's Signature <u>[Signature]</u>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09204

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN MICHAEL MCGUINNESS				2. Date of Death Month MARCH Day 07 Year 2000		3. Time of Death 1635	
	4a. Facility Name (If not institution, give street and number) 10213 LORAIN AVENUE				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 114-09-6468		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 22, 1920	9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent							
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 10213 Lorain Avenue				10f. Zip Code 20901		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker		16b. Kind of Business/Industry Retail Bakery		
17. Father's Name (First, Middle, Last) "unknown"				18. Mother's Name (First, Middle, Maiden Surname) "unknown"				
19a. Informant's Name/Relationship (Type, Print) Claire E.C. Schell/granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 Blackburn Lane #14 Burtonsville MD 20866				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomic Gift Foundation		20c. Location - City or Town, State 3/8/20 Laurel, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Anatomic Gift Foundation 13948 Baltimore Avenue Laurel MD 20707				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Cancer						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
24a. Was an autopsy performed? 1 Yes 2 No						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier
29c. License number 015236				29d. Date signed (Month, Day, Year) MARCH 07, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL E. MARGOLIS, MD. (OMB) 1125 ROCKFELLER PIKE, ROCKVILLE, MD 20852								
31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten notes at the top of the page, including the word "SPECIAL" and other illegible text.

Handwritten notes in the middle section, including the word "SPECIAL" and other illegible text.

Handwritten notes in the lower middle section, including the word "SPECIAL" and other illegible text.

Handwritten notes at the bottom of the page, including the word "SPECIAL" and other illegible text.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09205

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Zola P. McNulty

2. Date of Death
Month Day Year

MARCH 5, 2000

3. Time of Death

7:05 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

9250 EDWARDS WAY #406

4b. City, Town, or Location of Death

ADELPHI

4c. County of Death

PRINCE GEORGES

5. Social Security Number

578-50-3415

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

March 9, 1905

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

ADELPHI

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9250 EDWARDS WAY #406

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

George Price

18. Mother's Name (First, Middle, Maiden Surname)

Lavinia Roundtree

19a. Informant's Name/Relationship (Type, Print)

Barbara McNulty DeVore/Daughter 9250 Edwards Way #406, Adelphi, MD 20783

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

03-08-00 Suitland, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bernie L. Jones

22. Name and Address of Facility

Chambers Funeral Home, P.A.
5801 Cleveland Ave., Riverdale, MD 2073723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Pulmonary Failure

Due to (or as a consequence of):

30 days

c. Carcinoma Lung & Pleural Effusion

Due to (or as a consequence of):

90 days

d. Coronary Artery disease

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

Cancer Breast

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bernie L. Jones

29c. License number

D17843

29d. Date signed (Month, Day, Year)

03/06/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vivek C. Vaid 3311 Toledo Terrace 162 B 20782 Hyattsville MD

State
Registrar

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

Bernie L. Jones

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

CCCC

CCCC-CCCC

CCCC-CCCC-CCCC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09206

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia V. Midkiff

2. Date of Death

March 02, 2000

3. Time of Death

1852

4a. Facility Name (If not Institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

219-34-9526

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 24, 1932

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11427 Rosedale Lane

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Marion J. Quesinberry

18. Mother's Name (First, Middle, Maiden Surname)

Effie

Bowman

19e. Informant's Name/Relationship (Type, Print)

Linda Joyce Clem (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11427 Rosedale Lane Beltsville, Maryland 20705

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cemetery 3/6/2000 Adelphi, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Sepsis

3 days

b.

Due to (or as a consequence of):

Renal failure

3 days

c.

Due to (or as a consequence of):

Ventricular arrhythmia

1 day

d.

Due to (or as a consequence of):

Respiratory failure

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Timothy McClain MD

29c. License number

D39532

29d. Date signed (Month, Day, Year)

3/3/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Timothy McClain MD 321 Prince George St Laurel MD 20707

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09207

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ladson A. Mills Jr.

2. Date of Death

Month

Day

Year

March 1, 2000

3. Time of Death

8:00 A.M.

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

212-24-4549

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 27, 1909

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

800 Bestgate Rd

10f. Zip Code

21401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Rental Agent

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Ladson Mills Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Lenoir Jones

19a. Informant's Name/Relationship (Type, Print)

Ladson A. Mills III / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

212 King St., Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Hill Cemetery

Date

3/3/2000

20c. Location - City or Town, State

Washington D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's & Sons, 5130 Wisconsin Ave. N.W.
Washington D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicidal 4 ☐ Homicidal
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

045297

29d. Date signed (Month, Day, Year)

3-1-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elaine Arata MD 104 Ridgely Suite 201 Annapolis MD

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09208

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ada

Louise

Mock

2. Date of Death

Month Day Year
March 6, 2000

3. Time of Death

7:00P.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

218-20-0918

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 13, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9111 Gracious End Court, #104

10f. Zip Code

21046

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Prince George's
County Schools

17. Father's Name (First, Middle, Last)

Thomas

Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Ada

E.

Much

19a. Informant's Name/Relationship (Type, Print)

Raymond Gregory Mock (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6402 Darwin Road Laurel, Maryland 20707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery 3/9/2000

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Low CARDIAC OUTPUT

Due to (or as a consequence of):

Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

MONTHS

c. POOR LEFT VENTRICULAR FUNCTION

Due to (or as a consequence of):

MONTHS

SEVERE CALCIFIC AORTIC STENOSIS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

CALCIFIED ASCENDING AORTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sam R. Neimat MD

29c. License number

D18551

29d. Date signed (Month, Day, Year)

MARCH 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sam R. Neimat MD, 7610 Carroll Ave. Takoma Park, MD 20912

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

Prava G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

3-22-2000 WR

Certificate of Death

00 09209

JAMAL MOHAMMED

AMEND ITEMS: #23 PART I, 27 PER MEO G781

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMAL MOHAMMED				2. Date of Death Month Day Year MARCH 1, 2000		3. Time of Death 1914 PM	
	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				4b. City, Town, or Location of Death TAKOMA PARK		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 215-11-8349	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 17 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9-14-82		9. Birthplace (State or Foreign Country) Wash, D.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince Geo.		10c. City, Town or Location Lewisdale		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2225 Charleston Pl.				10f. Zip Code 20783		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed		16b. Kind of Business/Industry None			
	17. Father's Name (First, Middle, Last) MOHAMMED Babah				18. Mother's Name (First, Middle, Maiden Surname) Zainab Nyamekye			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mohammed Babah- Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2225 Charleston Pl, Lewisdale, Md. 20783			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Wash. Cemet.		Date 3-3-2000		20c. Location - City or Town, State Adelphi, Md.	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility UNIVERSAL MORTUARY INC. 411 Kennedy St, N.W., Wash, D.C.			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANOMALOUS CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 2, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Wilson Love MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09210

Amend #19a, 3/14/2000, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY C. MORGAN

2. Date of Death

03 03 2000

3. Time of Death

8:50am

4a. Facility Name (If not institution, give street and number)

VANTAGE HOUSE
5400 VANTAGE POINT RD

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

5. Social Security Number

577-70-8814

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 12, 1902

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3807 Taylor Street

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Daniel Joseph Clinton

18. Mother's Name (First, Middle, Maiden Surname)

Jane McDonaugh

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Lawrence/
Niece/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3807 Taylor Street, Chevy Chase, MD. 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

3/6/2000 Washington, D.C.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael Blahut

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End Stage Alzheimer Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recent viral gastroenteritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D-34866

29d. Date signed (Month, Day, Year)

03-03-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Diana Spear 11055 Little Patuxent Pk Columbia MD 21044

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

1944

April 11

Friday

Dear Mr. [Name]

Thank you for your letter of April 10.

I am sorry that I cannot

reply to you more quickly.

I am sure that you will

understand my position.

I am very sorry that I

cannot do more for you.

I am sure that you will

understand my position.

I am very sorry that I

cannot do more for you.

I am sure that you will

understand my position.

I am very sorry that I

cannot do more for you.

I am sure that you will

understand my position.

I am very sorry that I

cannot do more for you.

I am sure that you will

understand my position.

I am very sorry that I

cannot do more for you.

I am sure that you will

understand my position.

I am very sorry that I

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09211

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Helen Murtaugh

2. Date of Death

March 2, 2000

3. Time of Death

11:35 AM

4a. Facility Name (If not institution, give street and number)

Montgomery Hospice Casey House in Rockville

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

215-76-5326

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 23, 1914

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Garrett Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

10912 Clermont Avenue

10f. Zip Code

20896

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Nicholas Steinmetz

18. Mother's Name (First, Middle, Maiden Surname)

Helene Scheer

19a. Informant's Name/Relationship (Type, Print)

Michael S. Murtaugh/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

41 N. Main St., Keedysville, Maryland 21756

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Mary's Cemetery

Date

March 4,
2000

20c. Location - City or Town, State

Doyleburg, Pennsylvania

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501
Chase, Inc.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Cerebrovascular Accident

Approximate
Interval Between
Onset and Death

16 days

Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☒ Other (Specify)

Hospice

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury et
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0037620

29d. Date signed (Month, Day, Year)

March 2, 2000

30. Name and address of person who completed cause of death (Item 28e) (Type, Print)

Mark S. Godec, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09212

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Naomi Anne Manuel						2. Date of Death Month Day Year March 2, 2000		3. Time of Death 0618	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER						4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 221-22-3856		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) 11-28-35		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Worcester		10c. City, Town or Location Stockton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 4761 Big Mill Rd.				10f. Zip Code 21863		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Provider			16b. Kind of Business/Industry Home Health Care		
	17. Father's Name (First, Middle, Last) Clifford Manuel Sr.						18. Mother's Name (First, Middle, Maiden Surname) Zola Brown			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Deborah Manuel (daughter)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 371 Pocomoke City, MD 21851			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Hope Cemetery			20c. Date 3/6/00		20d. Location - City or Town, State Stockton Md.		
	21. Signature of Funeral Service Licensee John A. Prince						22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 331 Pocomoke MD 21851			
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Metastatic Lung Cancer									
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
23c. Approximate Interval Between Onset and Death 6 mos										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier [Signature]		29c. License number 026278		29d. Date signed (Month, Day, Year) 3-2-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Conally MD 145E Carroll St. Salisbury, MD 21801										
31. Date filed (Month, Day, Year) MAR 08 2000		32. Registrar's Signature [Signature]								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09213

Amended #5, 3/16/00, BAG, Kent County

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JANET P. NORVIK

2. Date of Death

March 08

Day Year
2000

3. Time of Death

4 05 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Talbot Wing Heron Point

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

5. Social Security Number

067-14-9581
067-14-9571

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08/27/13

9. Birthplace (State or Foreign Country)

Brooklyn N.Y.

Usual Residence of Decedent

10a. State

Md

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 Campus Ave. Apt. 326

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give

Year or Dates:

No

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

House Wife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

O-Grant Esterbrook

18. Mother's Name (First, Middle, Maiden Surname)

Sydney Turnbull

19a. Informant's Name/Relationship (Type, Print)

Eiliv P. Norvik

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

326 Heron Point Chestertown, Md. 21620

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Cremations

Chester, Md

Date

3/9/00

20c. Location - City or Town, State

Chester, Md. 21619

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Willis Wells Funeral Service

211 Heron Point Chestertown, Md. 21620

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

1 year

b. VALVULAR CARDIOMYOPATHY

Due to (or as a consequence of):

>3 yrs.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

PULMONARY FIBROSIS

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0041587

29d. Date signed (Month, Day, Year)

3/8/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble, M.D., 122 Speer Road, Chestertown, MD 21620

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09214

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anne Hall Dunlop O'Connell

2. Date of Death

February 28 2000

3. Time of Death

3:00pm

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-18-5785

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 20 1917

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3510 Preston Court

10f. Zip Code

20815

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: white

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

home-maker

16b. Kind of Business/Industry

Homeowner

17. Father's Name (First, Middle, Last)

Marshall Carter Hall

18. Mother's Name (First, Middle, Maiden Surname)

Martha Grigg

19a. Informant's Name/Relationship (Type, Print)

Carter Stewart (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3333 Reservoir Rd. N.W. Washington, DC 20007

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National

Cemetery

Date

3/10/2000

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

Thomas E. Donabate

22. Name and Address of Facility

Joseph Gawler's Sons 5130 Wisconsin Ave. NW
Washington, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Gangrenous right colon

Due to (or as a consequence of):

c. Colonic Volvulus

Due to (or as a consequence of):

d. Aspiration pneumonia

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Allen Wolland

29c. License number

D0023525

29d. Date signed (Month, Day, Year)

3/1/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Wolland MD 11500 Old Georgetown Rd. Rockville, Md. 20852-2735

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

Geneva B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitANNE O'CONNELL
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09215

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Loren K. Olson				2. Date of Death Month Day Year March 2, 2000		3. Time of Death 9:00 AM.	
	4a. Facility Name (If not institution, give street and number) Brighton Gardens of Tuckerman				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-50-2708		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 28, 1914	
	9. Birthplace (State or Foreign Country) Wisconsin							
Usual Residence of Decedent								
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 5550 Tuckerman Lane #339				10f. Zip Code 20852		10g. Citizen of What Country? S.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer			16b. Kind of Business/Industry Legal	
17. Father's Name (First, Middle, Last) Alfred J. Olson				18. Mother's Name (First, Middle, Maiden Surname) Zella McPherson				
19a. Informant's Name/Relationship (Type, Print) Douglas K. Olson - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12031 Treeline Way, North Bethesda, Md. 20852				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Natioal Crematory		Date 3/9/2000		20c. Location - City or Town, State Falls Church, VA.		
21. Signature of Funeral Service Licensee Thomas E. Hambaker				22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. Aspiration Pneumonia Due to (or as a consequence of): b. Dysphagia Due to (or as a consequence of): c. Multi-infarct Dementia Due to (or as a consequence of): d.						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Gastro esophageal reflux disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) assisted living						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Albert K Lee, MD				29c. License number D31282		29d. Date signed (Month, Day, Year) March 8, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Albert Lee, MD. 8218 Wisconsin Ave. #105 Bethesda, Md. 20814								
31. Date filed (Month, Day, Year) MAR 10 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09216

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY A OUTTEN				2. Date of Death Month February Day 29 Year 2000		3. Time of Death 4:15 AM																							
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death BALTIMORE CITY																							
Funeral Director	5. Social Security Number 218-24-4675		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/24/28	9. Birthplace (State or Foreign Country) Virginia																						
	Usual Residence of Decedent																													
10a. State MD		10b. County Baltimore City		10c. City, Town or Location Baltimore City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																							
10e. Street and Number 4702 Greenhill Ave.				10f. Zip Code 21206		10g. Citizen of What Country? USA																								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Domestic																								
17. Father's Name (First, Middle, Last) Leon Sparrow				18. Mother's Name (First, Middle, Maiden Surname) Dessie Culp																										
19a. Informant's Name/Relationship (Type, Print) Albert Outten/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Apt B Arlen Rd, Baltimore, MD 21236																										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) First Baptist Cem		20c. Date 3/3/00		20d. Location - City or Town, State Pocomoke, MD																						
21. Signature of Funeral Service Licensee Michael A. Dean 101129				22. Name and Address of Facility Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851																										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																														
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Dilated Cardiomyopathy</td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Coronary Artery Disease</td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Hypertension</td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Diabetes Mellitus</td> <td>Years</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Dilated Cardiomyopathy	Years	Due to (or as a consequence of):			b.	Coronary Artery Disease	Years	Due to (or as a consequence of):			c.	Hypertension	Years	Due to (or as a consequence of):			d.	Diabetes Mellitus	Years
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Dilated Cardiomyopathy	Years																											
	Due to (or as a consequence of):																													
	b.	Coronary Artery Disease	Years																											
	Due to (or as a consequence of):																													
c.	Hypertension	Years																												
Due to (or as a consequence of):																														
d.	Diabetes Mellitus	Years																												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																														
Atrial Fibrillation, Gastrointestinal Bleeding, End Stage Renal Disease, Peripheral Vascular Disease																														
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																										
28f. Location (Street and Number or Rural Route Number, City or Town, State)																														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																														
29b. Signature and title of certifier Michael A. Dean - Dorsey MD				29c. License number 00054808		29d. Date signed (Month, Day, Year) February 29, 2000																								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. A. Balfour - Dorsey MD 504 Realm Court East, Odenton, MD																														
31. Date filed (Month, Day, Year) MAR 03 2000				32. Registrar's Signature [Signature]																										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09217

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN SAMUEL PARROTT				2. Date of Death Month MARCH Day 2 Year 2000		3. Time of Death 12:47 PM		
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 579-28-8573		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) JULY 1, 1927		
	9. Birthplace (State or Foreign Country) WASH. D.C.		10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4308 JOPLIN DR.		10f. Zip Code 20853		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RET. - BUSINESS MAN		16b. Kind of Business/Industry PRIVATE		17. Father's Name (First, Middle, Last) JOHN SHANNON PARROTT		18. Mother's Name (First, Middle, Maiden Surname) ELISABETH COMER	
19a. Informant's Name/Relationship (Type, Print) ANN E. PARROTT/WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		20c. Location - City or Town, State 3/5/00 RIVERDALE, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MOOO91 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EDEMA Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death MINUTES			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PROSTATE CANCER		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Robert P. Fields MD		29c. License number D34740 (ML)		29d. Date signed (Month, Day, Year) MARCH 2, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ROBERT P. FIELDS, M.D. 18111 PRINCE PHILIP DR., T-12, OLNEY, MD. 20832		31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09218

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MORRIS POSNER				2. Date of Death Month Day Year MARCH 4, 2000				3. Time of Death 5:40 AM	
	4a. Facility Name (If not institution, give street and number) MANOR CARE NURSING HOME				4b. City, Town, or Location of Death CHEVY CHASE				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 129-12-6785		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 85		8. Date of Birth Month Day Year JUNE 18, 1914		9. Birthplace (State or Foreign Country) INDIANA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 11621 LOCKWOOD DRIVE #101				10f. Zip Code 20904		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PATENT OFFICE CLERK				16b. Kind of Business/Industry UNITED STATES GOVERNMENT			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) SAMUEL POSNER				18. Mother's Name (First, Middle, Maiden Surname) BESSIE MEYER					
	19a. Informant's Name/Relationship (Type, Print) CECELIA POSNER (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11621 LOCKWOOD DRIVE #101 SILVER SPRING MD 20904					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GARDENS 3/6/00 FALLS CHURCH VA				20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE MD 20852					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COMPLICATIONS OF ARTERIOSCLEROSIS Due to (or as a consequence of): b. MYELOPROLITERATIVE DISORDER Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEVERE OSTEOARTHRITIS OSTEOMYELITIS LEFT FOOT								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number D20678		29d. Date signed (Month, Day, Year) MARCH 4, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWARDA M. BUDA, M.D. 3904 CLEVELAND STREET KENSINGTON MD 20895									
31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09219

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BURTON LOUIS PRINCE

2. Date of Death

MARCH 5, 2000

3. Time of Death

5:52 PM

4a. Facility Name (If not institution, give street and number)

876 Ivy League Lane

4b. City, Town, or Location of Death

Rockville

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

028-30-2186

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 31, 1940

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

876 Ivy League Lane

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: 48-89

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Program Manager

16b. Kind of Business/Industry

JAYCOR

17. Father's Name (First, Middle, Last)

Carl W. Prince

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Stafford

19a. Informant's Name/Relationship (Type, Print)

Sarah J. Prince (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

876 Ivy League Lane, Rockville, MD 20850

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Funeral Serv. 3/6/00

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC GASTRIC CARCINOMA

Approximate Interval Between Onset and Death

6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Victor Priego

29c. License number

023308

29d. Date signed (Month, Day, Year)

MARCH 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTOR M. PRIEGO, M.D. 6410 ROCKLEDGE DR. #625 BETHESDA, MD 20817

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

*Beverly B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09220

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OTHO FRANKLIN PRICE				2. Date of Death Month Day Year FEBRUARY 27, 2000		3. Time of Death 2150		
	4a. Facility Name (If not institution, give street and number) 5101 COASTAL HWY. #32				4b. City, Town, or Location of Death OCEAN CITY		4c. County of Death WORCESTER		
Funeral Director	5. Social Security Number 705-03-2510		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 9-8-14		
	9. Birthplace (State or Foreign Country) OHIO		10a. State MD		10b. County WORCESTER		10c. City, Town or Location OCEAN CITY		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 5101 COASTAL HWY.		10f. Zip Code 21842		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOTEL & RESTAURANT		16d. Kind of Business/Industry HOSPITALITY		17. Father's Name (First, Middle, Last) WILLIAM ROBY PRICE	
18. Mother's Name (First, Middle, Maiden Surname) BESSIE MAY STEPHENS		19a. Informant's Name/Relationship (Type, Print) IRENE SEIGFRIED NEICE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 2ND ST., BERNVILLE, PA., 19506		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY	
20c. Date 2-28		20d. Location - City or Town, State SALISBURY, MD.		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Heart Disease Due to (or as a consequence of): Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. ... Due to (or as a consequence of): c. ... Due to (or as a consequence of): d. ...	
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier 		29c. License number D39813	
29d. Date signed (Month, Day, Year) 2/28/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. H. Atkins 1104 Westbury Drive Solis MD 21804		31. Date filed (Month, Day, Year) MAR 01 2000		32. Registrar's Signature 		33. Registrar's Name B. Sparks	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

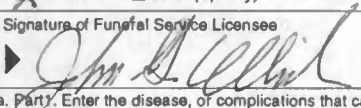


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09221

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN F. PECK				2. Date of Death Month 3 Day 5 Year 2000		3. Time of Death 1337						
	4a. Facility Name (If not institution, give street and number) 305 141ST STREET				4b. City, Town, or Location of Death OCEAN CITY		4c. County of Death WORCESTER						
Funeral Director	5. Social Security Number 073-05-9171		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 10-22-14						
	9. Birthplace (State or Foreign Country) NY		10a. State MD.		10b. County WORCESTER		10c. City, Town or Location OCEAN CITY						
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 305 141ST STREET		10f. Zip Code 21842		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMPUTER TECHNICIAN		16b. Kind of Business/Industry PROCESS CONTROL									
17. Father's Name (First, Middle, Last) ROBERT P. PECK				18. Mother's Name (First, Middle, Maiden Surname) MAE SORNBERGER									
19a. Informant's Name/Relationship (Type, Print) THOMAS D. PECK SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5382 ELIOTS OAK COLUMBIA, MD., 21044									
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ANATOMY BOARD		20c. Location - City or Town, State 3/7/00 BALTIMORE, MD.									
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD.									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ASCVD Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death SEVERAL YRS													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier 		29c. License number D06241		29d. Date signed (Month, Day, Year) 03-06-00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863													
31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature 											

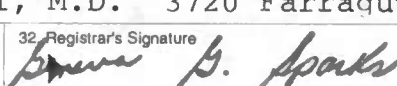
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09222

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HERMAN RANDOLPH		2. Date of Death Month Day Year MAR. 1, 2000		3. Time of Death 4:10 PM
	4a. Facility Name (If not institution, give street and number) Mariner Health of Kensington		4b. City, Town, or Location of Death Kensington		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 588-14-2326	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Feb. 17, 1900		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County Montgomery
	10c. City, Town or Location Gaithersburg		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 6624 Sundown Road		10f. Zip Code 20882		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance/U.S. Parks		16b. Kind of Business/Industry U.S. Government		
	17. Father's Name (First, Middle, Last) George R. Randolph		18. Mother's Name (First, Middle, Maiden Surname) Mary F. Jenkins		
	19a. Informant's Name/Relationship (Type, Print) Roland Randolph (Nephew)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 St. Margaret Dr., Capitol Heights, MD 20743		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.		20c. Location - City or Town, State 3/11/00 Silver Spring, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Acute Tubular Necrosis				Weeks
	Due to (or as a consequence of): b. Senile Inanition				Months
	Due to (or as a consequence of): c. _____				
	Due to (or as a consequence of): d. _____				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Progressive Dementia; Acute and Chronic Renal Failure; Hypertensive Cardiovascular Disease				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number D08944		29d. Date signed (Month, Day, Year) Mar. 2, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin C. Shargel, M.D. 3720 Farragut Ave., Kensington, MD 20895				
	31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 23a is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Handwritten signature or name, possibly "G. J. [illegible]"

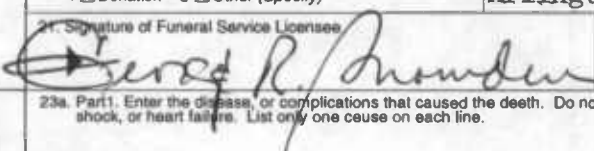
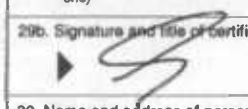
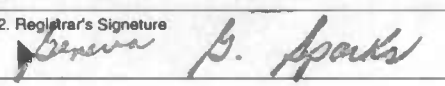
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09223

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED REDFIELD				2. Date of Death Month Day Year MARCH 6, 2000		3. Time of Death 8:04 AM		
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 216-22-0501		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 22, 1924		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 2419 Lytonsville Rd., #302		10f. Zip Code 20910		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home			
17. Father's Name (First, Middle, Last) John Williams				18. Mother's Name (First, Middle, Maiden Surname) Nellie Stewart					
19a. Informant's Name/Relationship (Type, Print) Robin Redfield - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5362 43rd Street, NW, Washington, DC 20015					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat'l Cem.		Date 3/15/00		20c. Location - City or Town, State Arlington, VA			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of): b. Atherosclerotic Heart Disease Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number D0054493		29d. Date signed (Month, Day, Year) 03/06/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Trotzky, M.D. 1500 Forest Glen Rd., Silver Spring, MD 20910									
31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09224

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Mary A. Reid</u>				2. Date of Death Month <u>March</u> Day <u>5</u> Year <u>2000</u>				3. Time of Death <u>7:00 am</u>	
	4a. Facility Name (If not institution, give street and number) <u>Holy Cross Rehabilitation and Nursing Ctr.</u>				4b. City, Town, or Location of Death <u>Burtonsville</u>				4c. County of Death <u>Montgomery</u>	
Funeral Director	5. Social Security Number <u>452-40-6726</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <u>74</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Nov 24, 1925</u>		9. Birthplace (State or Foreign Country) <u>Texas</u>	
	Usual Residence of Decedent									
10a. State <u>Maryland</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Wheaton</u>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <u>11701 Lytle Street</u>				10f. Zip Code <u>20902</u>				10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>				16b. Kind of Business/Industry <u>Own Home</u>		
17. Father's Name (First, Middle, Last) <u>Marvin Carpenter</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Annie Halbert</u>						
19a. Informant's Name/Relationship (Type, Print) <u>Crafton M. Reid / Husband</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>11701 Lytle Street, Wheaton, MD 20902</u>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metropolitan Crematory</u>		20c. Date <u>3/7/00</u>		20d. Location - City or Town, State <u>Alexandria, VA</u>				
21. Signature of Funeral Service Licensee <u>Steven D. Stord</u>				22. Name and Address of Facility <u>Francis J. Collins Funeral Home, Inc.</u> <u>500 University Blvd., W. Silver Spring, MD 20901</u>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. <u>Chronic Obstructive Pulmonary Disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death <u>less than 5 years</u>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Congestive Heart Failure</u>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Rahul Gilotra</u>				29c. License number <u>D 32417</u>		
				29d. Date signed (Month, Day, Year) <u>March 5, 2000</u>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Rahul Gilotra, MD 12016 Georgia Ave., Wheaton, MD 20902</u>										
31. Date filed (Month, Day, Year) <u>MAR 06 2000</u>				32. Registrar's Signature <u>B. Sparks</u>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09225

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>BARBARA LEE Robinson</u>				2. Date of Death Month <u>March</u> Day <u>6</u> Year <u>2000</u>		3. Time of Death <u>0620</u>	
	4a. Facility Name (If not institution, give street and number) <u>SHADY GROVE ADVENTIST HOSPITAL</u>				4b. City, Town, or Location of Death <u>ROCKVILLE</u>		4c. County of Death <u>MONTGOMERY</u>	
Funeral Director	5. Social Security Number <u>213-56-1406</u>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>52</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Apr 26, 1947</u>		9. Birthplace (State or Foreign Country) <u>DC</u>
	Usual Residence of Decedent							
10a. State <u>Maryland</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Germantown</u>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <u>13103 Briarcliff Terrace #1002</u>				10f. Zip Code <u>20874</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Computer Processing</u>		16b. Kind of Business/Industry <u>Health Care</u>		
17. Father's Name (First, Middle, Last) <u>Lawrence William Robinson</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret Elizabeth Weast</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Mother</u> <u>Margaret Elizabeth Robinson</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>13103 Briarcliff Terrace #1002, Germantown, MD 20874</u>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metropolitan Crematory</u>		20c. Location - City or Town, State <u>3/7/00 Alexandria, VA</u>				
21. Signature of Funeral Service Licensee <u>P. Ryan McMillan</u>				22. Name and Address of Facility <u>Francis J. Collins Funeral Home, Inc.</u> <u>500 University Blvd., W, Silver Spring, MD 20901</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Metastatic Squamous Cell CA.</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>H51280</u>		29d. Date signed (Month, Day, Year) <u>3-6-2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>ANUSH INDURAO. 9901 Medical Center Drive, Rockville, MD 20850</u>								
31. Date filed (Month, Day, Year) <u>MAR 08 2000</u>		32. Registrar's Signature <u>[Signature]</u>						

ORIGINAL

Handwritten text, possibly a signature or date, located in the upper middle section of the page.

Handwritten text, possibly a signature or date, located in the lower left section of the page.

Handwritten text, possibly a signature or date, located in the lower right section of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09226

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene E. Robinson

2. Date of Death

March 6, 2000

3. Time of Death

3:16pm

4a. Facility Name (If not institution, give street and number)

3383 South Leisure World Blvd. #2-C

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-40-2413

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 2, 1915

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3383 South Leisure World Blvd. #2-C

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supply Specialist

16b. Kind of Business/Industry

General Services

17. Father's Name (First, Middle, Last)

Wallace Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Ennis

19a. Informant's Name/Relationship (Type, Print)

Mary E. Robinson (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3383 South Leisure World Blvd #2-C
Silver Spring, Maryland 20906

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Data

Mar. 10

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Eric S. Scerbo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b. congestive Heart Failure

Due to (or as a consequence of):

c. old Myocardial Infarction

Due to (or as a consequence of):

d. Atrial Fibrillation

Approximate
Interval Between
Onset and Death

years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident 6 investigation
3 Suicide 6 Could not be
4 Homicide 6 determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

1 Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. R. L. M. A.

29c. License number

D18612

29d. Date signed (Month, Day, Year)

March 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. ALBERTO ROTSZTAJN - 3305 N. Leisure world Blvd. S. Spring Md.

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09227

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie P. Rowell

2. Date of Death

March 4, 2000

3. Time of Death

12:50 AM

4a. Facility Name (If not institution, give street and number)

Winter Growth

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577 34 6947

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

June 7, 1908

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14107 Heathfield Court

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Dorsey Pritchard

18. Mother's Name (First, Middle, Maiden Surname)

Mae McCarthy

19a. Informant's Name/Relationship (Type, Print)

Evan A. Scott/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14107 Heathfield Court, Rockville, Maryland, 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

March

7, 2000

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Alamy Donnell

22. Name and Address of Facility

Hines- Rinaldi Funeral Home

11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:2 ☐ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bennett Morrison M.D.

29c. License number

D 47682

29d. Date signed (Month, Day, Year)

March 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett Morrison, M.D., 2901 Olney-Sandy Spring Road, Olney, Maryland, 20832

State
Registrar

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

Bennett Morrison

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2000.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09228

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Orilee Alley Scheid

2. Date of Death
Month Day Year

March 2, 2000

3. Time of Death

18:30

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Bayside Nursing Center

4b. City, Town, or Location of Death

Lexington Park

4c. County of Death

St. Mary's

5. Social Security Number

278-09-4990

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Sept. 7, 1915

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21412 Great Mills Road

10f. Zip Code

20653

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Elisha Alley

18. Mother's Name (First, Middle, Maiden Surname)

Molly Patton

19a. Informant's Name/Relationship (Type, Print)

Patricia Ann Rodriguez - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

44348 Tall Timbers Road Tall Timbers, MD 20690

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Memorial Burial Park

Date

3/7/00

20c. Location - City or Town, State

Wheelersburg, Ohio

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.

5517 Vine Street Alexandria, VA 22310

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebrovascular Accident
Due to (or as a consequence of):b. Hypertension
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

About one hour.
15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

SC Baby M.D.

29c. License number

D54346

29d. Date signed (Month, Day, Year)

3/3/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Chandra Sajja, MD

Hollywood, Maryland 20636

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

Brown B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09229
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louise Marian Shew

2. Date of Death

Month Day Year
March 6, 2000

3. Time of Death

6:25 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

174-18-3785

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
Oct. 18, 1914

9. Birthplace (State or Foreign Country)

Altoona, PA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

411 Thayer Place

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Dry Cleaner

17. Father's Name (First, Middle, Last)

Jan Podgorsky

18. Mother's Name (First, Middle, Maiden Surname)

Marian (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Russell J. Shew (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

411 Thayer Place Silver Spring, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Calvary Cemetery

Date

3/9/00

20c. Location - City or Town, State

Altoona, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Capitol Funeral Service, Inc.

7211 Lee Highway Falls Church, VA 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Pulmonary Emphysema

Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

22309

29d. Date signed (Month, Day, Year)

March 07, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Phillip Poth P.O. Box 3025 Silver Spring, Md. 20918

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2000-1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09230

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sheila

D.

Slay

2. Date of Death

March 4, 2000

3. Time of Death

6:25P.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Crescent Cities Nursing Center

4b. City, Town, or Location of Death

Riverdale

4c. County of Death

Prince Georges

5. Social Security Number

227-64-9681

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 22, 1949

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4816 Olympia Avenue

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Operations Manager

16b. Kind of Business/Industry

Crab State, Inc.

17. Father's Name (First, Middle, Last)

Thomas

Doyle

18. Mother's Name (First, Middle, Maiden Surname)

Florence B. Crofts

19a. Informant's Name/Relationship (Type, Print)

Jean A. Langway (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4804 Manheim Avenue Beltsville, Maryland 20705

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 3/6/2000

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL CARCINOMA
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Roger B. Ingham

29c. License number

D05891

29d. Date signed (Month, Day, Year)

March 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6510 KENILWORTH AVE, NORTON, MD 20777

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

Roger B. Ingham

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

August 19, 1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09231

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald B. Smith				2. Date of Death Month Day Year March 4, 2000		3. Time of Death 10:45 PM										
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick										
Funeral Director	5. Social Security Number 216-22-0776		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) June 24, 1928										
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick										
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2503 Coach House Way		10f. Zip Code 21702		10g. Citizen of What Country? United States										
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No World War II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Auto Parts Store												
	17. Father's Name (First, Middle, Last) Archibald Smith				18. Mother's Name (First, Middle, Maiden Surname) Helen Beard												
	19a. Informant's Name/Relationship (Type, Print) Therese E. Smith/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Coach House Way, Frederick, Maryland 21702												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Mar. 8 2000 Silver Spring, MD												
	21. Signature of Funeral Service Licensee <i>[Signature]</i> M00803				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Non small cell lung cancer</td> <td>18 m.</td> </tr> <tr> <td>b. Bladder Cancer</td> <td>18 m</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Non small cell lung cancer	18 m.	b. Bladder Cancer	18 m	c.		d.	
	Immediate Cause (Final disease or condition resulting in death)	a. Non small cell lung cancer	18 m.														
b. Bladder Cancer		18 m															
c.																	
d.																	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined																	
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <i>[Signature]</i> MD																	
29c. License number D 48184																	
29d. Date signed (Month, Day, Year) 3/5/2000																	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy ESKander MD 501 W 7th Str. Frederick MD 21701																	
31. Date filed (Month, Day, Year) MAR 06 2000																	
32. Registrar's Signature <i>[Signature]</i>																	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09232

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kathleen

Smith

2. Date of Death

Feb. 29, 2000

3. Time of Death

11:40 AM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Magnolia Center

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George

5. Social Security Number

502-12-7175

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 14, 1901

9. Birthplace (State or Foreign Country)

York, England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8200 Good Luck Road

10f. Zip Code

20722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Housewife

17. Father's Name (First, Middle, Last)

Herbert Harry Pilmoor

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Powell

19a. Informant's Name/Relationship (Type, Print)

Barbara Miller - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3414 40th Pl., Colmar, Md. 20722

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

National Crematory

Date

3/10/2000 Falls Church, Va.

21. Signature of Funeral Service Licensee

Thomas E. Lombaker

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.
5130 Wisc. Ave. NW., Washington, D.C. 2001623a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Arrhythmia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

Years

c. Atherosclerotic Heart Disease

Due to (or as a consequence of):

Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Spinal Stenosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

Raman R. Tuli, MD.

29c. License number

D19609

29d. Date signed (Month, Day, Year)

March 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman R. Tuli, MD., 10810 Darnestown Road #202, Gaithersburg, Md. 20878-2675

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

Raman R. Tuli

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

S

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09233

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine C. Stein

2. Date of Death

Feb 28th 2000

3. Time of Death

2:00 Am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

014-14-5120

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 16, 1920

9. Birthplace (State or Foreign Country)

MASSACHUSETTS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6121 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ECONOMIST

16b. Kind of Business/Industry

LABOR DEPARTMENT

17. Father's Name (First, Middle, Last)

DAVID CLUCK

18. Mother's Name (First, Middle, Maiden Surname)

ELLA (UNASCERTAINABLE)

19a. Informant's Name/Relationship (Type, Print)

HELEN L. WOLFE - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

130 NEW MARK ESPLANADE, ROCKVILLE, MARYLAND 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GARDEN

Date

3/1/2000

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute cardio-pulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. coronary artery disease

Due to (or as a consequence of):

c. cerebrovascular accident (acute)

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dysphagic depression peripheral neuropathy

diabetes mellitus osteoporosis

hypertension H/O cerebrovascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Consul Morgan

29c. License number

D: 44907

29d. Date signed (Month, Day, Year)

Feb 28th 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121 Montrose Road Rockville, MD 20852

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Stein Josephine

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09234

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAUL STERNFELD				2. Date of Death Month Day Year MARCH 1, 2000		3. Time of Death 1:30 P.M.																							
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY																							
Funeral Director	5. Social Security Number 165-14-2178	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCTOBER 10, 1920	9. Birthplace (State or Foreign Country) OHIO																							
	Usual Residence of Decedent																													
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																							
	10a. Street and Number 6111 MONTROSE ROAD, APARTMENT # 516				10f. Zip Code 20854		10g. Citizen of What Country? U. S. A.																							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: ARMY 2		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANICAL ENGINEER		16b. Kind of Business/Industry COMPUTERS																									
	17. Father's Name (First, Middle, Last) SAMUEL STERNFELD				18. Mother's Name (First, Middle, Maiden Surname) REBECCA LAURIE																									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JOANN LEVIN-DOWNEY - DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9900 MAINSAIL DRIVE, GAITHERSBURG, MARYLAND 20879																									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR PARK CEMETERY MARCH 3, 2000		20c. Location - City or Town, State PARAMUS, NEW JERSEY																									
	21. Signature of Funeral Service Licensee Donald C. Stottmeyer				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852																									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																													
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>ASPIRATION PNEUMONIA</td> <td>HOURS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>CONGESTIVE HEART FAILURE</td> <td>HOURS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td>UROSEPSIS</td> <td>DAYS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>TYPE II DIABETES</td> <td>YEARS</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	ASPIRATION PNEUMONIA	HOURS	Due to (or as a consequence of):			b.	CONGESTIVE HEART FAILURE	HOURS	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	UROSEPSIS	DAYS	Due to (or as a consequence of):			d.	TYPE II DIABETES
Immediate Cause (Final disease or condition resulting in death)	a.	ASPIRATION PNEUMONIA	HOURS																											
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	b.	CONGESTIVE HEART FAILURE	HOURS																											
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	Due to (or as a consequence of):																													
	d.	TYPE II DIABETES	YEARS																											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																								
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																								
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																								
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																														
29b. Signature and title of certifier S. Abulfarag				29c. License number D 31391		29d. Date signed (Month, Day, Year) MARCH 1, 2000																								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Abulfarag, M. D. 481 N. FREDERICK AVENUE, GAITHERSBURG, MARYLAND 20879																														
State Registrar	31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature B. Sparks																											

ORIGINAL

my mother's

January 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09235

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD C. TEMPLE

2. Date of Death

March 2, 2000

3. Time of Death

12:08am

4a. Facility Name (If not institution, give street and number)

2009 St. Thomas Drive

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

St. Charles

Funeral
Director

5. Social Security Number

577-32-8299

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Apr. 14, 1928

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2009 St. Thomas Drive

10f. Zip Code

20602

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Specialist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Solomon Temple

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ball

19a. Informant's Name/Relationship (Type, Print)

Drucilla Simms - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10804 Joyceton Court, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem.

Date

3/10/00

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.
600 Kennedy Street, N.W., DC, 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic heart disease
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yahia M. Tagour: MD

29c. License number

D0050883

29d. Date signed (Month, Day, Year)

3-2-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25500 Point Lookout RD. Leonardtown, MD 20650

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-0028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09236

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nancy A. Tuell				2. Date of Death Month Day Year March 3, 2000				3. Time of Death 1805	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-24-6510		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 26, 1922		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 7501 Democracy Boulevard				10f. Zip Code 20817	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home				17. Father's Name (First, Middle, Last) Lee King	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Nora Gibbons				19a. Informant's Name/Relationship (Type, Print) Raymond E. Chappell/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10013 Gainsborough Road, Potomac, Maryland 20854	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat'l Cemetery 2000				20c. Location - City or Town, State Arlington, Virginia	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Daniel E. Perry				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiovascular Arrest Due to (or as a consequence of): Colonial Rupture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Crohn's Disease	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Howard S. Goldstein				29c. License number D. 20388	
	29d. Date signed (Month, Day, Year) March 4, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard S. Goldstein, M.D. 4701 Randolph Road, #105, Rockville, MD 20852-2293				31. Date filed (Month, Day, Year) MAR 06 2000	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature B. Sparks				33. State Registrar MAR 06 2000				34. State Registrar	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09237

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AURA V. VOGELFANGER

2. Date of Death

Month Day Year
MARCH 5, 2000

3. Time of Death

2303

4a. Facility Name (If not Institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

119-46-2467

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Montha Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
06.14.1937

9. Birthplace (State or Foreign Country)

ROMANIA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

GAITHERSBURG

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

15200 TIMONIUM PLACE

10f. Zip Code

20878

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

BUSINESS OWNER

16b. Kind of Business/Industry

SKIN CARE

17. Father's Name (First, Middle, Last)

JOSEF TAPU

18. Mother's Name (First, Middle, Maiden Surname)

DORETTA ROEDER

19a. Informant's Name/Relationship (Type, Print)

MARIUS VOGELFANGER/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15200 TIMONIUM PLACE, GAITHERSBURG, MD 20878

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MENORAH GARDENS

Date

MARCH
8, 2000

20c. Location - City or Town, State

ROCKVILLE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PULMONARY EMBOLISM

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

MIN

b. METASTATIC BREAST CANCER

Due to (or as a consequence of):

15 YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D47093

29d. Date signed (Month, Day, Year)

MARCH 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. "THAI" MARTIN MCGREIVY, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09238

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VICTOR VINOGRADOV				2. Date of Death Month 3 Day 4 Year 2000				3. Time of Death 0859			
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN				4c. County of Death WORCESTER			
Funeral Director	5. Social Security Number 065-30-5043		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) 3-13-25		9. Birthplace (State or Foreign Country) RUSSIA			
	Usual Residence of Decedent				10a. State MD.				10b. County WORCESTER		10c. City, Town or Location BERLIN	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 11003 GRAYS CORNER RD.				10f. Zip Code 21811		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TOOL AND DIE				16b. Kind of Business/Industry DEFENSE INDUSTRY			
	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MICHAEL VINOGRADOV				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAY STREET BERLIN, MD. 21811							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY				20c. Location - City or Town, State 3-7 SALISBURY, MD.			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. 21811							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary artery disease Due to (or as a consequence of):								Approximate Interval Between Onset and Death Yrs			
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):											
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperkalemia								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D 41721		29d. Date signed (Month, Day, Year) 03/06/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHAN PAVLOS 400 EASTERN SHORE DR. SALISBURY MD 21804											
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) MAR 06 2000				32. Registrar's Signature 							

MAR 6 8 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09239

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET FRANCES VOSS				2. Date of Death Month 3 Day 6 Year 2000		3. Time of Death 1700		
	4a. Facility Name (If not institution, give street and number) ISLE OF WIGHT PARK				4b. City, Town, or Location of Death OCEAN CITY		4c. County of Death WORCESTER		
Funeral Director	5. Social Security Number 215-16-6852		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) 4-16-23		
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County WORCESTER		10c. City, Town or Location OCEAN CITY		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number ISLE OF WIGHT PARK		10f. Zip Code 21842		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME					
17. Father's Name (First, Middle, Last) JAMES FERDINAND GRIMES				18. Mother's Name (First, Middle, Maiden Surname) ANNA MARIE LUBER					
19a. Informant's Name/Relationship (Type, Print) MARTIN A. VOSS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISLE OF WIGHT PARK OCEAN CITY, MD. 21842					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY		Date 3-7		20c. Location - City or Town, State SALISBURY, MD.			
21. Signature of Funeral Service Licensee <i>John D. Ullrich</i>				22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. 21811					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Vascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Joseph B. McShane P.O.</i>		29c. License number H51718		29d. Date signed (Month, Day, Year) 3/7/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph B. McShane P.O. 10514 Rockwell Rd, Unit C Berlin MD 21811		31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature <i>John D. Ullrich</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09240

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Isabel M. Ward AKA: Isabella M. Ward

2. Date of Death

March 4, 2000

3. Time of Death

3:05 AM

4a. Facility Name (If not institution, give street and number)

Wilson Health Care

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577 30-7505

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months

If Under 24 Hrs.

Hours

6. Date of Birth

Feb 14, 1904

8. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16550 Emory Lane

10f. Zip Code

20853

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Charles Myers

18. Mother's Name (First, Middle, Maiden Surname)

Isabel Mellis

19a. Informant's Name/Relationship (Type, Print)

Jane S. Brow daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16550 Emory Lane, Rockville, Maryland 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

March 6, 2000

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

[Signature] M00092

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. urosepsis
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumoniadementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D19294

29d. Date signed (Month, Day, Year)

March 4, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN R. MELNICH 511 RUSSELL AVE GAITHERSBURG, Md. 20879

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09241

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Liesel Wetzl				2. Date of Death Month March Day 3 Year 2000				3. Time of Death 12:15AM															
	4a. Facility Name (If not institution, give street and number) Montgomery Village Care & Rehabilitation				4b. City, Town, or Location of Death Montgomery Village				4c. County of Death Montgomery															
Funeral Director	5. Social Security Number 071-28-3887		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 28, 1907		9. Birthplace (State or Foreign Country) Germany															
	Usual Residence of Decedent																							
10a. State Virginia		10b. County Fairfax		10c. City, Town or Location Fairfax				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
10e. Street and Number 9203 Jeffrey Road				10f. Zip Code 22066		10g. Citizen of What Country? United States																		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home																	
17. Father's Name (First, Middle, Last) Not Available				18. Mother's Name (First, Middle, Maiden Surname) Maria Louise Schneider																				
19a. Informant's Name/Relationship (Type, Print) Ralph F. Wetzl/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9203 Jeffrey Road, Great Falls, Virginia 22066																				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mountainview Cemetery		Date Mar. 7, 2000		20c. Location - City or Town, State New Fairfield, CT																
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805																				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. Cerebrovascular Accident</td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. Right Hemiplegia</td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____</td> <td colspan="2"></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Cerebrovascular Accident	Years	Due to (or as a consequence of):		b. Right Hemiplegia	Years	Due to (or as a consequence of):		c. _____	Due to (or as a consequence of):		d. _____		
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Cerebrovascular Accident	Years																						
	Due to (or as a consequence of):																							
	b. Right Hemiplegia	Years																						
	Due to (or as a consequence of):																							
c. _____	Due to (or as a consequence of):																							
d. _____																								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																								
29b. Signature and title of certifier 				29c. License number D31391		29d. Date signed (Month, Day, Year) March 6, 2000																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhair H. Abulfarag, M.D. 481 North Frederick Road, Gaithersburg, Maryland 20879																								
31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature 																						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-1000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09242

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cleveland White Sr.				2. Date of Death Month Day Year March 4, 2000		3. Time of Death 0740 AM	
	4a. Facility Name (If not institution, give street and number) Rt. 615 and Interstate 70				4b. City, Town, or Location of Death Hancock		4c. County of Death Washington	
Funeral Director	5. Social Security Number 426-68-1065		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	8. Date of Birth (Month, Day, Year) May 29, 1935	9. Birthplace (State or Foreign Country) Mississippi		
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State DE		10b. County New Castle		10c. City, Town or Location Newark		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 42 Fairway Rd Apt 1B				10f. Zip Code 19711		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Casting		16b. Kind of Business/Industry Ironworker			
	17. Father's Name (First, Middle, Last) Samuel White				18. Mother's Name (First, Middle, Maiden Surname) Marcella Williams			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Debra Sue Hartman White				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Fairway Rd Apt. 1B Newark, Delaware 19711			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenwood Cemetery		Date 3/10/00		20c. Location - City or Town, State Wast Burlington, Iowa	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Capitol Funeral Service 7211 Lee Hwy Falls Church, VA 22046			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries and Due to (or as a consequence of): Compressional Ashpyxia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 3/4/00		28b. Time of Injury 0555 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred Driver of Motor Vehicle lost Control and Ejected with vehicle on Road		28f. Location (Street and Number or Rural Route Number, City or Town, State) Street; Rt 615 and I 70 Hancock, Md					
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier  M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 05, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 penn street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) MAR 10 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09243

Amended #14, 19b, 20c, 3/9/2000, JW, Mont. Co.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN

WINEYAN

2. Date of Death

Month

Day

Year

MARCH 02 2000

3. Time of Death

11 45 AM

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

216-18-3566

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 16, 1916

9. Birthplace (State or Foreign

Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

none

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1824 Riggs Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: ~~White~~ Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Health Aide

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Robert Lee Davis

18. Mother's Name (First, Middle, Maiden Surname)

Annie Drew

19a. Informant's Name/Relationship (Type, Print)

Josephine D. Sprattley (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36168 Broadwater Road Ivor, VA 23866

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Davis Family Cemetery

Date

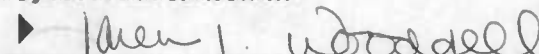
3/5/00

20c. Location - City or Town, State

Ivor

Ivor, VA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Metropolitan Funeral Service, Inc.

5517 Vine Street Alexandria, VA 22310

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

SEPSIS

Approximate
Interval Between
Onset and Death

2 DAYS

Immediate Cause (Final
disease or condition
resulting in death)

a. INFECTED DECUBITUS ULCER WITH

Due to (or as a consequence of):

b. URINARY TRACT INFECTION

Due to (or as a consequence of):

UNKNOWN

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

OLD CEREBRO-VASCULAR ACCIDENT

SIP COLOSTOMY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 M.D.

29c. License number

D 23300

29d. Date signed (Month, Day, Year)

MARCH 02 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDHIR, D. PATEL 2000 W. BALTO ST. BALTO, MD. 21223

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09244

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE WASHINGTON WOODFIELD

2. Date of Death

Month Day Year
MARCH 5 2000

3. Time of Death

7:45 A.M.

4a. Facility Name (If not institution, give street and number)

Reeder's Memorial Home Inc.

4b. City, Town, or Location of Death

Boonesboro

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

579-42-7779

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 25, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19620 Cool Hollow Way

10f. Zip Code

21740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Procurement Officer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Thomas Woodfield

18. Mother's Name (First, Middle, Maiden Surname)

Emma Boyer

19a. Informant's Name/Relationship (Type, Print)

Marianne W. Cardea (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16920 Cool Hollow Way Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Oak Cemetery

Date

Mar. 8, 2000

20c. Location - City or Town, State

Gaithersburg, Md.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. chronic obstructive pulmonary disease
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma colon Cervix varicellaArteriosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28l. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Curtis E. Day

29c. License number

D18019

29d. Date signed (Month, Day, Year)

MARCH 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. VASANT DATTA

334 MILL STREET, HAGERSTOWN, MD. 21740

301-739-7100

State
Registrar

31. Date filed (Month, Day, Year)

MAR 08 2000

32. Registrar's Signature

B. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

J.W. GEORGE W. WOODFIELD

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09245

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES O. WORMLEY JR.				2. Date of Death Month MARCH Day 8 Year 2000		3. Time of Death 3:32 AM		
	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				4b. City, Town, or Location of Death TAKOMA PARK		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 577-12-4557		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 4, 1918		
	9. Birthplace (State or Foreign Country) WASHINGTON, D.C.		10a. State D.C.		10b. County NONE		10c. City, Town or Location WASHINGTON		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4212 20th ST. N.E.		10f. Zip Code 20018		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COST ACCOUNTANT		16b. Kind of Business/Industry FED. GOV'T.		17. Father's Name (First, Middle, Last) JAMES O. WORMLEY SR.		18. Mother's Name (First, Middle, Maiden Surname) SALLY DYSON		19a. Informant's Name/Relationship (Type, Print) EVELYN WORMLEY/WIFE	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		20c. Location - City or Town, State 3/10/00 RIVERDALE, MD.		21. Signature of Funeral Service Licensee W. W. Chambers MO0091	
22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYOCARDIAL INFARCTION		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier 9+1 HAMMETT MD		29c. License number 39966		29d. Date signed (Month, Day, Year) 03/08/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLYN A. HAMMETT, M.D. 344 UNIVERSITY BLVD. #326, SILVER SPRING, MD. 20901		31. Date filed (Month, Day, Year) MAR 10 2000	
32. Registrar's Signature B. Sparks									

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09246

Amend #8, 3/6/2000, BW, Montg. Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HANNAH YEFFMAN				2. Date of Death Month Day Year FEB. 27, 2000				3. Time of Death 1:45 AM	
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 057.03.6848		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 2000 Sept. 14, 1911		9. Birthplace (State or Foreign Country) AUSTRIA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 825 GREGORIO DRIVE				10f. Zip Code 20901		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME	
	17. Father's Name (First, Middle, Last) YAACOV SHULIM				18. Mother's Name (First, Middle, Maiden Surname) HENIA RACHAL					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) PAUL YEFFMAN/SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 SLIGO CREEK PKWY, TAKOMA PARK, MD 20912					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GDNS		20c. Date FEB. 28, 2000		20d. Location - City or Town, State FALLS CHURCH, VA			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, RENAL INSUFFICIENCY, ANEMIA									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
12	29b. Signature and title of certifier Robert F. Musselman MD				29c. License number D42715		29d. Date signed (Month, Day, Year) Feb. 27, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT F. MUSSELMAN, MD 10801 LOCKWOOD DRIVE #200, SILVER SPRING, MD 20901									
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09247

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT LOUIS ZUEGER, SR.				2. Date of Death Month Day Year Feb. 28, 2000				3. Time of Death 0615	
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center				4b. City, Town, or Location of Death Salisbury				4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 219-36-5425		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60		8. Date of Birth (Month, Day, Year) April 14, 1939		9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent									
10a. State Md.		10b. County Worcester		10c. City, Town or Location Girdletree				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7241 Cherrix Road				10f. Zip Code 21829				10g. Citizen of What Country? US		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1958-78		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Army				16b. Kind of Business/Industry Military		
17. Father's Name (First, Middle, Last) Lester Elmer Heiser				18. Mother's Name (First, Middle, Maiden Surname) Mary Louise Zueger						
19e. Informant's Name/Relationship (Type, Print) Gloria Zueger (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7241 Cherrix Rd., Girdletree, Md. 21829						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Whatcoat Cemetery		Date 3-1-00		20c. Location - City or Town, State Snow Hill, Md.				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility The Burbage Funeral Home 208 W. Federal St., Snow Hill, Md. 21863						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 HOUR 5 YEARS		
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number D05865		29d. Date signed (Month, Day, Year) Feb. 29, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert C. LaMar, M.D. 104 N. Bay St., Snow Hill, Md. 21863										
31. Date filed (Month, Day, Year) MAR 01 2000		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 24e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10+1

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09248

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM AUSTIN

2. Date of Death

03-19-2000

3. Time of Death

8:pm

4a. Facility Name (If not institution, give street and number)

7885 BASTILLE PLACE

4b. City, Town, or Location of Death

SEVERN

4c. County of Death

ANNEARUNDEL

Funeral
Director

5. Social Security Number

226-34-5065

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09-18-30

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

7885 BASTILLE PLACE

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COORDINATOR

16b. Kind of Business/Industry

SUBSTANCE ABUSE

17. Father's Name (First, Middle, Last)

COLLINS HAMLETT

18. Mother's Name (First, Middle, Maiden Surname)

MARY ANN AUSTIN

19a. Informant's Name/Relationship (Type, Print)

MICHAEL AUSTIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7885 BASTILLE PLACE SEVERN MARYLAND 21144

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON VETERANS CEM.

Date

3/28/2000

20c. Location - City or Town, State

ARLINGTON VA.

21. Signature of Funeral Service Licensee

James G. Morton II

22. Name and Address of Facility

JAMES A. MORTON & SONS FUNERAL HOME

1701 LAURENS STREET BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LEIOMYOSARCOMA METASTATIC TO THE

Due to (or as a consequence of):

b. BRAIN

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alvin Kuhn II

29c. License number

D21336

29d. Date signed (Month, Day, Year)

3/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALVIN KUHN II, M.D., 9028 RITCHIE HWY, PASADENA, MD. 21122

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

Benita S. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09249

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARRIET ANGLE				2. Date of Death Month Day Year MARCH 9, 2000				3. Time of Death 11:30 PM	
	4a. Facility Name (If not institution, give street and number) EASTPOINT NURSING HOME				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 410-14-1630		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) April 26, 1912		9. Birthplace (State or Foreign Country) AL	
	Usual Residence of Decedent									
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1046 Old North Point Road				10f. Zip Code 21222				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) bookkeeper				16b. Kind of Business/Industry unknown		
17. Father's Name (First, Middle, Last) Daniel Webster Walker				18. Mother's Name (First, Middle, Maiden Surname) Harriet Emma Lokey						
19a. Informant's Name/Relationship (Type, Print) Robin Burner/P.R.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11521 Cedar Lane Kingsville, MD 21087						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Central Vascular Accident - Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier [Signature]				29c. License number D43725				29d. Date signed (Month, Day, Year) 3/15/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOUD 201-109 Back River Neck Road Baltimore MD 21221										
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1950

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1950

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1950

1950

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09250

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCIS

ROBERT

ARZT

2. Date of Death

March 19, 2000

3. Time of Death

10:35am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

VA MEDICAL CENTER, FORT HOWARD, MD 21052

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

BALTIMORE

5. Social Security Number

220-07-2469

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3-10-21

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6210 BENHURST ROAD

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER

16b. Kind of Business/Industry

APPLIANCE STORE

17. Father's Name (First, Middle, Last)

HERBERT

ARZT

18. Mother's Name (First, Middle, Maiden Surname)

ROSA

WOLFF

19a. Informant's Name/Relationship (Type, Print)

MONA ARZT / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6210 BENHURST ROAD - BALTIMORE, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW CEMETERY 3/21/00 REISTERSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE SCLEROSIS

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D52739

29d. Date signed (Month, Day, Year)

March 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH SHANDELYA, M.D., VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052

State
Registrar

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

ORIGINAL

AKA: ARZT, FRANCIS R.

Division of Vital Records, P.O. Box 68760,

15X1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 00 09251

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Tyrone Brown, Jr.				2. Date of Death Month Day Year MARCH 18, 2000		3. Time of Death 0320 AM		
	4a. Facility Name (If not institution, give street and number) 1634 RALWORTH AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA		
Funeral Director	5. Social Security Number 061-62-1586		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09-25-77		9. Birthplace (State or Foreign Country) NY
	Usual Residence of Decedent								
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1634 Ralworth Avenue				10f. Zip Code 21218		10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Assistant		16b. Kind of Business/Industry Company			
17. Father's Name (First, Middle, Last) Tyrone Brown, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Quinsanna McFadden					
19a. Informant's Name/Relationship (Type, Print) Mary Wheeler				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Shadyside Baltimore, Maryland 21218					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		Date 03-24-2000		20c. Location - City or Town, State Dundalk, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue					
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot and Shotgun Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 3/18/00		28b. Time of Injury 2:55 A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT WAS SHOT	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 1634 Ralworth Ave. Baltimore, MD			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 18, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TIRUS, M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

CURTIS BAILEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09252

ASP

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CURTIS BAILEY						2. Date of Death Month Day Year MARCH 07 2000			3. Time of Death 1:52 A														
	4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL						4b. City, Town, or Location of Death BALTIMORE			4c. County of Death N/A														
Funeral Director	5. Social Security Number unknown		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 61 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) April 29, 1938													
	9. Birthplace (State or Foreign Country) unknown																							
Usual Residence of Decedent																								
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 Yes 2 No																
10e. Street and Number 3404 Clifton Ave						10f. Zip Code 21216			10g. Citizen of What Country? USA															
11. Marital Status unknown 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: black															
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown			16b. Kind of Business/Industry unknown															
17. Father's Name (First, Middle, Last) unknown						18. Mother's Name (First, Middle, Maiden Surname) unknown																		
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201																		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State																
21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>CARDIAC ARRHYTHMIA</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>												Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CARDIAC ARRHYTHMIA	Due to (or as a consequence of):	b.	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	CARDIAC ARRHYTHMIA	Due to (or as a consequence of):																					
	b.	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	Due to (or as a consequence of):																					
	c.		Due to (or as a consequence of):																					
	d.		Due to (or as a consequence of):																					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																								
25. Was case referred to medical examiner? Yes 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred														
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																								
29b. Signature and title of certifier J. M. Titus						29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) MARCH 07, 2000															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201																								
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature B. Sparks																				

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09253

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Joseph Bogdan, Sr.

2. Date of Death

March 20, 2000

3. Time of Death

11:50 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

218-28-6471

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 23, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4719 Ballygar Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Date

Korean Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Cable Company

17. Father's Name (First, Middle, Last)

John J. Bogdan

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Oles

19a. Informant's Name/Relationship (Type, Print)

Bernardine J. Bogdan (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4719 Ballygar Road, Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem.

Date

3/22/00

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Wm. Fialkowski

22. Name and Address of Facility

Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marco Zamora

29c. License number

D40819

29d. Date signed (Month, Day, Year)

March 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Marco Zamora 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

B. Sparks

State
RegistrarBogdan, John
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09254

AMENDED ITEM #26 PER MD G781 3/22/2000 AH

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas J. BRENNAN

2. Date of Death
Month Day Year
February 29, 20003. Time of Death
0640

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

198-22-5395

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 6, 1910

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State
MD.10b. County
N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2518 E. BALTIMORE ST.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

ACCOUNTING FIRM

17. Father's Name (First, Middle, Last)

MICHAEL BRENNAN

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE MULDON

19a. Informant's Name/Relationship (Type, Print)

JAMES BRENNAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

32 REA AVE. MIDLAND PARK N.J. 07432

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

METRO CREMATORY

Date

MARCH 8
2000

20c. Location - City or Town, State

BALTO. CO. MD.

21. Signature of Funeral Service Licensee

Thomas J. Brennan

22. Name and Address of Facility

SKARDA F.H. 2829 HUDSON ST
BALTO. MD. 2122423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 week

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

1 week

c. Respiratory failure

Due to (or as a consequence of):

4 days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐
☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Eric Yang, M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC Yang, M.D. 600 N. Wolfe Street Baltimore, MD 21287

31. Date filed (Month, Day, Year)

MARCH 2, 2000

32. Registrar's Signature

N. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09255

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT B COLBERT JR.				2. Date of Death Month Day Year March 20 2000		3. Time of Death 18:55	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical System				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-05-1463		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) March 31, 1916	
	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Towson		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 731 Camberly Cr. Apt. C-6				10f. Zip Code 21204		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW-II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Budget Manager		16b. Kind of Business/Industry National Brewing Co.	
	17. Father's Name (First, Middle, Last) Robert B. Colbert, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Harriett Edwards			
	19a. Informant's Name/Relationship (Type, Print) Miss Robin B. Colbert/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3602 Heathers Way Baltimore, Md. 21234			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		Date 3/25/00		20c. Location - City or Town, State Baltimore, Md.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis and Septic Shock Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 72 Hours							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multisystem Trauma Congestive Heart Failure						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number WI#34149		29d. Date signed (Month, Day, Year) March 21 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHET MORRISON UMMS 29 South Greene Street, Baltimore, Md 21201								
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09256

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BRUCE CARTER				2. Date of Death Month Day Year FEBRUARY 17, 2000				3. Time of Death 21:19	
	4a. Facility Name (If not institution, give street and number) 1939 WEST NORTH AVE.				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number unknown		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) Sept 17, 1960		9. Birthplace (State or Foreign Country) unknown	
	Usual Residence of Decedent									
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1939 W. North Avenue				10f. Zip Code 21217				10g. Citizen of What Country? USA		
11. Marital Status unknown 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown				16b. Kind of Business/Industry unknown		
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown						
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Seizure Disorder Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Joseph Pestaner, M.D.				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) FEBRUARY 18, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks								

1974

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09257

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Margaret Charvat				2. Date of Death Month Day Year March 17, 2000		3. Time of Death 9:40 am	
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-01-2552	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	8. Date of Birth (Month, Day, Year) Oct. 15, 1918	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 509 N. Kenwood Avenue				10f. Zip Code 21205		10g. Citizen of What Country? U. S. A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) George Smith				18. Mother's Name (First, Middle, Maiden Surname) Eva Collins				
19a. Informant's Name/Relationship (Type, Print) James R. Charvat (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Boxthorn Road, Abingdon, Maryland 21009				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National Cem.		20c. Location - City or Town, State 3/22/00 Baltimore, Maryland				
21. Signature of Funeral Service Licensee Mark T. [Signature]				22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. overwhelming sepsis (with VRE) 4 days Due to (or as a consequence of): b. acute renal failure due to above 4 days Due to (or as a consequence of): c. resolved ARDS/ bilat. interstitial pneumonia 3 wks Due to (or as a consequence of): d. met. rectal carcinoma 3 2/3 yrs								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. type II diabetes / COPD / long history of HTN								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier Ruth Kantor M.D.				29c. License number D28594		29d. Date signed (Month, Day, Year) 3/18/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruth Kantor, M.D. 6569 N. Charles Street, Baltimore MD, 21204								
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09258

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosann Conner				2. Date of Death Month Day Year March 20, 2000				3. Time of Death 8:00am	
	4a. Facility Name (If not institution, give street and number) Country Home				4b. City, Town, or Location of Death Harwood				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 578-32-5219		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Sept. 6, 1915		9. Birthplace (State or Foreign Country) Washington, DC		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location 1917 Mitchellville Road, Bowie	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1917 Mitchellville Road		10f. Zip Code 20716		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Legal					
	17. Father's Name (First, Middle, Last) Francis Fleishman				18. Mother's Name (First, Middle, Maiden Surname) Grace Cockrill					
	19a. Informant's Name/Relationship (Type, Print) Gail Chetelat - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1917 Mitchellville Road, Bowie, MD 20716					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 3/21/2000		20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensee <i>Michael P. Kutta</i>				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <i>Yrs</i>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Don Walker MD</i>				29c. License number 130718		29d. Date signed (Month, Day, Year) 3-21-2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Don Walker, 2003 Legical Hwy 4100, Annapolis MD 21401</i>										
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature <i>Don Walker</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09259

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Cook Carlin					2. Date of Death Month Day Year March 18 2000			3. Time of Death 12:45am		
	4a. Facility Name (If not institution, give street and number) Atlantic General Hospital					4b. City, Town, or Location of Death Berlin			4c. County of Death Worcester		
Funeral Director	5. Social Security Number 579-01-0701		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 02-09-1916		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent										
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Linthicum				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 805 Camp Meade Road				10f. Zip Code 21090			10g. Citizen of What Country? U.S.A				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (14 or 5+) 9				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Payroll			16b. Kind of Business/Industry Westinghouse				
17. Father's Name (First, Middle, Last) Laurence Cook					18. Mother's Name (First, Middle, Maiden Surname) Anna Whitting						
19a. Informant's Name/Relationship (Type, Print) Elsie C. Joy / Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Yawl Drive Ocean City, MD 21842						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial			20c. Location - City or Town, State Elkridge, MD		20d. Date 3-21-2000			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Ave. S.W. Glen Burnie, MD 21061						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Arteriosclerotic Heart Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Deputy 					29c. License number D06054		29d. Date signed (Month, Day, Year) 3/21/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 America 21035											
31. Date filed (Month, Day, Year) MAR 22 2000			32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09260

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED DAVIS				2. Date of Death Month Day Year MARCH 3, 2000		3. Time of Death 7:50 PM		
	4a. Facility Name (If not institution, give street and number) MANOR CARE HEALTH CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 218-09-0338	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 25, 1921		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md	10b. County Baltimore	10c. City, Town or Location Towson			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 509 E. Joppa Road			10f. Zip Code 21286		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) none		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) bookkeeper		16b. Kind of Business/Industry unknown				
	17. Father's Name (First, Middle, Last) William H. Heintz				18. Mother's Name (First, Middle, Maiden Summa) Albertina A. Krueger				
To Be Completed by Physician/Medical Examiner	19a. Intendant's Name/Relationship (Type, Print) Manor Care Health Care			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 E. Joppa Rd Towson, MD 21286					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>			22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septicemia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last chronic renal insufficiency Due to (or as a consequence of): Approximate Interval Between Onset and Death one week								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus chronic renal insufficiency								
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number D37016		29d. Date signed (Month, Day, Year) March 16, 2000		
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Kenneth M. Green, MD 6701 N. Charles St, Suite 4105 Baltimore, MD 21204								
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09261
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clifford Lee Dunston

2. Date of Death
Month Day Year
March 20, 20003. Time of Death
6:45 pm

4a. Facility Name (If not institution, give street and number)

1221 Crawford Dr.

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

AA

Funeral
Director

5. Social Security Number

420-62-5884

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 12, 1947

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1221 Crawford Drive

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1966-

1973

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Officer in Army/Airforce

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Hamilton

18. Mother's Name (First, Middle, Maiden Surname)

Dunson

19. Informant's Name/Relationship (Type, Print)

Artelie

20. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pearson

19a. Informant's Name/Relationship (Type, Print)
Della Ann Jackson- Sister19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1221 Crawford Drive, Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem.

Date

3/27/00

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Singleton Funeral Home, PA.

1 Second Avenue, SW., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma, Lung.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Deputy
William P. Jones, MD

29c. License number

D06054

29d. Date signed (Month, Day, Year)

3/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09262

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Lee Divers Sr.

2. Date of Death

March 17 2000

3. Time of Death

2210

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-07-3990

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-26-19

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2538 Arunch Ave.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Fork Lift operator

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

William A. Divers

18. Mother's Name (First, Middle, Maiden Surname)

Nancy M. Price

19a. Informant's Name/Relationship (Type, Print)

Rose M. Divers / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2538 Arunch Ave. Balto. MD. 21216

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Cemetery

Date

3-22-00

20c. Location - City or Town, State

Balto. MD

21. Signature of Funeral Service Licensee

Vaughn C. Green

22. Name and Address of Facility

Vaughn C. Green Funeral Services
5151 Balto. Nat'l Pk. Balto. MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cerebrovascular Accident

Due to (or as a consequence of):

b.

Intracerebral hemorrhage

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

19 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

Dorcas Thomas MD

29d. License number

RES-000

29e. Date signed (Month, Day, Year)

March 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorcas Thomas 2001 West Belvedere Avenue, Baltimore MD, 21215

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

P. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09263

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED N. DEAN				2. Date of Death Month 03 Day 19 Year 00				3. Time of Death 1:00 PM	
	4a. Facility Name (If not institution, give street and number) 1027 CATHEDRAL STREET APT 5K				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 2166-24-9791		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 12-14-13		9. Birthplace (State or Foreign Country) FL	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1027 CATHEDRAL STREET APT 5K				10f. Zip Code 21201				10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH GRADE College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROGRAM MGMT. SPECIALIST				16b. Kind of Business/Industry FEDERAL GOVT.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JAKE FLAGLER				18. Mother's Name (First, Middle, Maiden Surname) JANIE BAKER					
	19a. Informant's Name/Relationship (Type, Print) JIM DEAN SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87-36 CHELSEA ST, JAMAICA STATE NY 11432					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. CALVARY CEMETERY				20c. Date 03-23-00		20d. Location - City or Town, State BALTO. MD	
	21. Signature of Funeral Service Licensee Daugh C H				22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE BALTO. MD. 21229					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death) a. Acute Renal Failure Due to (or as a consequence of):									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Squamous cell carcinoma of Urinary Bladder Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number 042979		29d. Date signed (Month, Day, Year) 3/21/2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLF STREET BALTIMORE MD 21287										
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature [Signature]								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AMEND ITEM: #8 PER F.H. G782 4-18-00 WR.

00 09264

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM DRYDEN				2. DATE OF DEATH MONTH 03 DAY 13 YEAR 2000		3. TIME OF DEATH 10:50 a.m.	
4. SOCIAL SECURITY NUMBER 212-20-4578		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH OCT 5, 1924	
9a. FACILITY NAME (If not institution, give street and number) Genesis Eldercare Multi Medical Ctr				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7700 York Road				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) truck driver		16b. KIND OF BUSINESS/INDUSTRY armour express			
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia			
19a. INFORMANT'S NAME (Type/Print) Robert Ferguson/nephew				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade, Director				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST COPD, PNEUMONIA, COLON CANCER							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD, PNEUMONIA, COLON CANCER							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER W. Wade				29c. LICENSE NUMBER D52360		29d. DATE SIGNED (Month, Day, Year) 3/13/00	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KUBIR SANDHU - 1838 GREEN TREE RD, SUITE 300, PICESBURG MD 21078							
31. DATE FILED (Month, Day, Year) MAR 22 2000		32. REGISTRAR'S SIGNATURE Benjamin S. Sparks					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09265

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Myrtle I. Findley				2. Date of Death Month Day Year MARCH 15 2000		3. Time of Death 10 ⁰⁵ PM	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HEALTHCARE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 225-18-8086		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) June 28, 1911	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2416 Marbourn Avenue		10f. Zip Code 21230	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Collega (14 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Joseph Widener	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Minerva Debusk				19a. Informant's Name/Relationship (Type, Print) Peggy A. Damron-Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3209 Rosalie Road, Baltimore, Maryland 21227	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Hills Cemetery		20c. Location - City or Town, State Towson, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service licensee Lisa S. Johnson				22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. SICK SINUS SYNDROME Due to (or as a consequence of): d. ADULT RESPIRATORY DISTRESS SYNDROME				Approximate Interval Between Onset and Death 2 WEEKS MONTHS MONTHS 2 WEEKS			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier MEDICAL RESIDENT P-13603			
	29c. License number 29d. Date signed (Month, Day, Year) MARCH, 16 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR CHARLES OWUSU, ST. AGNES HOSP. BALTIMORE, MD			
State Registrar	31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature Benita A. Spauld			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09266

AMEND#20b PER F.H. G782 4-4-2000 JAB

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

William P. Fields

2. Date of Death

March 21, 2000

3. Time of Death

3:35 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hec Hicare

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-32-2823

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 6, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4724 Dartford Ave.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12th
College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Radio

17. Father's Name (First, Middle, Last)

unk.

18. Mother's Name (First, Middle, Maiden Surname)

Alice Butcher

19a. Informant's Name/Relationship (Type, Print)

Lena M. Fields - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4724 Dartford Ave. Balto, MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of ARBUTUS cemetery, crematory or other place)

Western Star Cemetery

Date

3-27-00

20c. Location - City or Town, State

Catonsville, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Earl P. March Funeral Home P.A.
2700 Frederick Pass Balto, MD. 21289

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Liver Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hepatic Metastasis

Due to (or as a consequence of):

Months

c. Lung Cancer

Due to (or as a consequence of):

one year

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

P12595

29d. Date signed (Month, Day, Year)

March 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mustapha Mallah 400 Caton Avenue Baltimore, MD 21228

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09267

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Foster Fanseen				2. Date of Death Month Day Year March 15 2000		3. Time of Death 2:00 AM	
	4a. Facility Name (If not institution, give street and number) 20 Weems Creek Dr.				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 216-20-7934		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) February 3, 1928	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 20 Weems Creek Dr.		10f. Zip Code 21401		10g. Citizen of What Country? United States	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) attorney		16b. Kind of Business/Industry legal			
	17. Father's Name (First, Middle, Last) Foster H. Fanseen				18. Mother's Name (First, Middle, Maiden Surname) Lillian Seguire			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Radelle F. Rittenhouse/sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1055 W. Joppa Rd. Towson, MD 21204			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. Location - City or Town, State Pikesville, Maryland		20d. Date 3/18/00	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee John B. Mitchell IV				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC RENAL CELL CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 16 MONTHS			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL INSUFFICIENCY				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Katherine Dunleavy MD				29c. License number D00 53456		29d. Date signed (Month, Day, Year) March 15, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHERINE DUNLEAVY 139 OLD SOLOMONS ISLAND ROAD ANNAPOLIS, MARYLAND 21401							
State Registrar	31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature B. Sparks			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09268

AMENDED ITEM #20b & #20c PER FH G781 3/31/2000 AH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna Elaine Greene				2. Date of Death Month: March Day: 17 Year: 2000				3. Time of Death 7:20 pm				
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore City				4c. County of Death				
Funeral Director	5. Social Security Number 213-32-8544		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) 10/07/1934		9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent				10a. State Maryland				10b. County Baltimore		10c. City, Town or Location Baltimore		
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 3800 Belvedere Ave.				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951 1955		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Adult Educator				16b. Kind of Business/Industry Instruction					
17. Father's Name (First, Middle, Last) Arthur Foreman				18. Mother's Name (First, Middle, Maiden Surname) Rosa Carter									
19a. Informant's Name/Relationship (Type, Print) Audrey Mayfield / Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Druid Pk. Lake Dr. Apt. 202, Baltimore, Maryland 21217									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MT ZION CEMETERY Garrison Forest VA Ceme.				20c. Location - City or Town, State LANDSDOWNE, MD Gwings Mills, Maryland		20d. Date 03/24/00			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Esophageal Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholism & Hypertension													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Ana Maria Palhete, MD				29c. License number 89354		29d. Date signed (Month, Day, Year) 3/17/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ana Maria Palhete, M.D. 60 Maryland General Hospital													
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature Benjamin B. Sparks									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

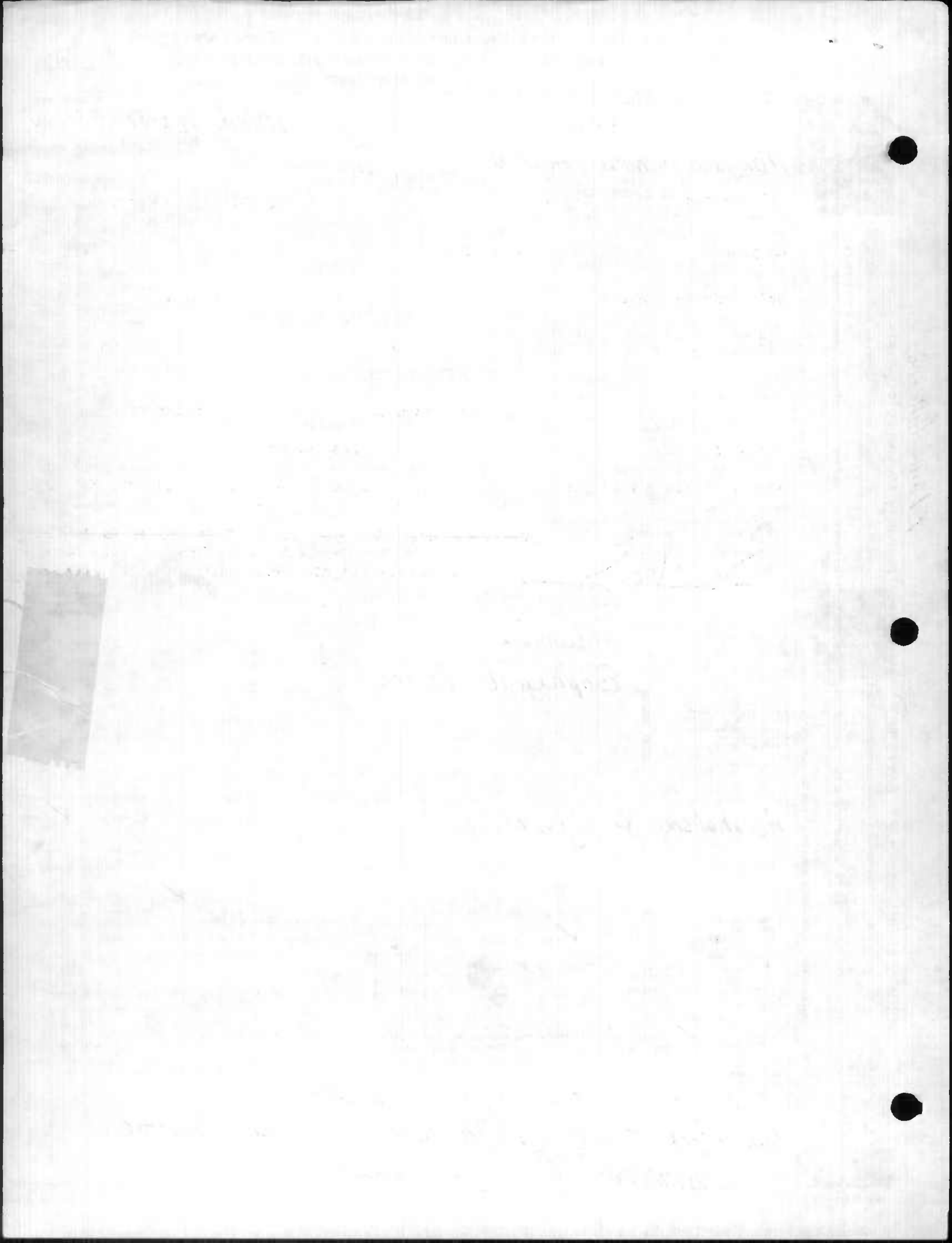
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09269
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ISSAAC GOLLAHON

2. Date of Death
Month Day Year
MARCH 01, 2000

3. Time of Death
17:35

4a. Facility Name (If not institution, give street and number)

3001 BELAIR ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

unknown

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Sept 17, 1934

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3001 Belair Road

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

unknown

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Penn Street Baltimore, MD 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration OF BOLUS OF

Due to (or as a consequence of):

b. FOOD Occluding Airway

Due to (or as a consequence of):

c. IN ASSOCIATION WITH Cerebrovascular

Due to (or as a consequence of):

d. Accident and Brain Neoplasm, not otherwise specified

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural

5 ☐ Pending investigation

2 ☒ Accident

6 ☐ Could not be determined

3 ☐ Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

3/1/00

28b. Time of Injury

16 30

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject Choked on Food

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home; 3001 Belair Road; Baltimore, Md

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph Pestaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 02, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

BESSIE GOCHENOUR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09270

AMENDED ITEM #26 PER MD G781 3/22/2000 AH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bessie Alice Gochenour				2. Date of Death Month Day Year Feb 19, 2000		3. Time of Death 8:30 am	
	4a. Facility Name (If not institution, give street and number) 1931 Crafton Avenue				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 224-28-5462	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	8. Date of Birth (Month, Day, Year) Mar 5, 1910	9. Birthplace (State or Foreign Country) Va.			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Va.	10b. County Shenandoah	10c. City, Town or Location Woodstock		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 149 Valley Vista Drive, Apt 203		10f. Zip Code 22664		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 yrs. College (1-4or 5+) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Lewis Wetzel				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Peters			
	19a. Informant's Name/Relationship (Type, Print) Loy E. Gochenour				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Coffmantown Rd. Woodstock, Va. 22664			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Valley Pike Ch of the Brethren Cem		20c. Location - City or Town, State Feb 22, 2000 Maurertown, Va.			
	21. Signature of Funeral Service Licensee Anthony C. Connelly				22. Name and Address of Facility Connolly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Pend Carcinoma</u> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 mth							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) DAUGHTER'S HOME						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Louis O. Olsen MD		29c. License number D0018648		29d. Date signed (Month, Day, Year) 2/21/2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOUIS O. OLSEN MD 1576 MERRITT BLVD BRMD 21222 MD								
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09271

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD D. GRAVES

2. Date of Death

Month Day Year
MARCH 14, 2000

3. Time of Death

2:05 PM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS NURSING HOME

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

101-28-1829

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb 8, 1937

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

4510 Cedargarden Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

engineer

16b. Kind of Business/Industry

technical

17. Father's Name (First, Middle, Last)

Charlie Graves

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Williams

19a. Informant's Name/Relationship (Type, Print)

Yvonne Williams/friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4510 Cedargarden Rd Baltimore, MD 21229

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimor Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

8 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

3/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Richard Graves March 14, 2000 2:05 P.M.

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09272

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Genevieve E. Howard				2. Date of Death Month Day Year March 17, 2000		3. Time of Death 9:10 P.M.	
	4a. Facility Name (If not institution, give street and number) 911 Delray Drive				4b. City, Town, or Location of Death Forrest Hill		4c. County of Death Harford	
Funeral Director	5. Social Security Number 219-16-8499		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) 8-14-1924	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 8430 Pleasant Plains Road		10f. Zip Code 21286	
	10g. Citizen of What Country? U. S. A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII Navy	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Receptionist				16b. Kind of Business/Industry Greetings & Readings			
	17. Father's Name (First, Middle, Last) Harry Breidenstein				18. Mother's Name (First, Middle, Maiden Surname) Agnes Bayne			
	19a. Informant's Name/Relationship (Type, Print) Mr. Marvin L. Howard, Jr. (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Delray Drive, Forrest Hill, Maryland 21050			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Hill Cemetery		20c. Location - City or Town, State Towson, Maryland	
	21. Signature of Funeral Service Licensee Wallace S. Brooks, Jr.				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of lung Due to (or as a consequence of):				Approximate Interval Between Onset and Death 3 years			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Carl S. Friedman, M.D.				29c. License number 020688		29d. Date signed (Month, Day, Year) 3/20/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl S. Friedman, M.D. 515 Fairmount Ave, Towson, MD 21286								
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature Genevieve E. Howard				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09273

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN . W. HALL				2. Date of Death Month Day Year MARCH 05 2000		3. Time of Death 1245		
	4a. Facility Name (If not institution, give street and number) BONSECOURS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 579-84-5007		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) April 12, 1908		
	9. Birthplace (State or Foreign Country) unknown		10a. State MD		10b. County N/A		10c. City, Town, or Location Baltimore		
Usual Residence of Decedent									
10e. Street and Number 1217 W. Fayette Street				10f. Zip Code 21223		10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: unknown			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: black		14. Race - American Indian, Black, White, etc. Specify: black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown			16b. Kind of Business/Industry unknown			
17. Father's Name (First, Middle, Last) unknown					18. Mother's Name (First, Middle, Maiden Surname) unknown				
19a. Informant's Name/Relationship (Type, Print) Bon Secours Hospital					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 W. Baltimore Street Baltimore, MD 21223				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state			20b. Place of Disposition (Name of cemetery, crematory or other place) State Anatomy Board		20c. Location - City or Town, State Baltimore, MD 21201		20d. Date 655 W. Baltimore Street		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. BRADYARRHYTHMIA Due to (or as a consequence of): c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): d.									
Approximate Interval Between Onset and Death MINUTES MINUTES YEARS									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RECURRENT PNEUMONIA						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)			28g. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Vasanthakumar			29c. License number D42510			29d. Date signed (Month, Day, Year) MARCH 15TH 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUTHUKRISHNAN VASANTHAKUMAR BON SECOURS HOSPITAL, BALTO., MD									
31. Date filed (Month, Day, Year) MAR 22 2000			32. Registrar's Signature G. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09274

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Haynes				2. Date of Death Month March Day 17 Year 2000				3. Time of Death 6:38 A.M.	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 248-80-6124		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 14, 1948		9. Birthplace (State or Foreign Country) S. Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 5115 Gwynn Oak Ave.				10f. Zip Code 21207		10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction				16b. Kind of Business/Industry Building			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) James Haynes				18. Mother's Name (First, Middle, Maiden Surname) Rosa Mae Haynes					
	19a. Informant's Name/Relationship (Type, Print) Jonika Haynes				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5115 Gwynn Oak Ave. Balto., Md. 21207					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 3-25-00 Lansdowne, MD.		21. Signature of Funeral Service Licensee Gary P. March			
	22. Name and Address of Facility 2400 Frederick Pass Balto., Md. 21229		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerosis Cardiovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 18, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201									
State Registrar	31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature [Signature]							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09275

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE HANNIBAL						2. Date of Death Month Day Year March 9, 2000		3. Time of Death 21:37		
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A				
Funeral Director	5. Social Security Number 220-09-4497		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Aug 11, 1920		9. Birthplace (State or Foreign Country) unknown		
	Usual Residence of Decedent										
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 5200 York Road				10f. Zip Code 21239			10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown				16b. Kind of Business/Industry unknown			
17. Father's Name (First, Middle, Last) unknown						18. Mother's Name (First, Middle, Maiden Surname) unknown					
19a. Informant's Name/Relationship (Type, Print) Union Memorial Hospital						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 E. University Pkwy Baltimore, MD 21218					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal bleeding Due to (or as a consequence of): b. Cerebrovascular Accident Due to (or as a consequence of): c. Atrial Fibrillation Due to (or as a consequence of): d. myocardial Infarction										Approximate Interval Between Onset and Death two hours fourteen hours unknown four days	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier MD						29c. License number AT2438946		29d. Date signed (Month, Day, Year) March 9, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Dressler MD 201 East University Parkway Baltimore, Maryland 21218											
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature B. Sparks							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 09276

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace M. Isola				2. Date of Death Month Day Year March 18, 2000		3. Time of Death 6:00 AM	
	4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 066-14-6381	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	8. Date of Birth (Month, Day, Year) April 26, 1907	9. Birthplace (State or Foreign Country) N.Y.			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore	10c. City, Town or Location Phoenix			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 3701 Duddington Way			10f. Zip Code 21131		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Banking		
	17. Father's Name (First, Middle, Last) John Isola				18. Mother's Name (First, Middle, Maiden Surname) Mamie Glasto			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Marie S. Isola/niece			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 Duddington Way Phoenix, Md. 21131				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Calvary Cemetery		20c. Date 3/21/00		20d. Location - City or Town, State Woodside, N.Y.	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Approximate Interval Between Onset and Death 2 yrs							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D30641		29d. Date signed (Month, Day, Year) March 20 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathur Suite 308 821 N-Eotaw St. Baltimore MD 21201								
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature 						

jhm
CARROLL F
JACKSON

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09277

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carroll F.C. Jackson, Sr.				2. Date of Death Month Day Year MARCH 10, 2000				3. Time of Death 15:20 PM	
	4a. Facility Name (If not institution, give street and number) 3928 ROKEBY ROAD				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death NA	
Funeral Director	5. Social Security Number 212-28-4428		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) 05-30-30		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 3928 Rokeby Road				10f. Zip Code 21229				10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Longshoreman				16b. Kind of Business/Industry Maryland Port Authority		
17. Father's Name (First, Middle, Last) James Crosby				18. Mother's Name (First, Middle, Maiden Surname) Beatrice Silva				21206		
19a. Informant's Name/Relationship (Type, Print) Dwon P. Simms				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4913 Goodnow Road Apt. "A" Baltimore, MD.						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem. 03-22-2000 Owings Mill		20c. Location - City or Town, State MD.				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March F.H. 1101 E. North Avenue						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number OCME		29d. Date signed (Month, Day, Year) MARCH 11, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09278

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM JOHNSON				2. Date of Death Month MARCH Day 21 Year 2000		3. Time of Death 4:00 AM	
	4a. Facility Name (If not Institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-70-0533		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 41 Yrs.		8. Date of Birth (Month, Day, Year) MAR. 31, 1958	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State Md.		10b. County N/A		10c. City, Town or Location BALTIMORE	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6811 YANTARUBA DRIVE		10f. Zip Code 21207		
10g. Citizen of What Country? U.S.A.		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. AFRO-AMERICAN		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HELPER		16b. Kind of Business/Industry SMITH TRANSFER CO.		
17. Father's Name (First, Middle, Last) WILLIAM JOHNSON, SR.				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY WILLIAMS				
19a. Informant's Name/Relationship (Type, Print) WILLIAM JOHNSON, III/SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6811 YANTARUBA DR. BALTO, MD. 21207				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK MAR. 24, 2000 BALTO, MD.				
21. Signature of Funeral Service Licensee <i>Bernadine V. Scruggs</i>				22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of): ANOXIC ENCEPHALOPATHY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 MONTHS				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year) MARCH 21, 2000				28b. Time of Injury M				
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i> MD				
29c. License number P13450				29d. Date signed (Month, Day, Year) MARCH 21, 2000				
30. Name and address of person who completed cause of death (item 23e) (Type, Print) KOFI A. APPIAH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE				31. Date filed (Month, Day, Year) MAR 22 2000				
32. Registrar's Signature <i>[Signature]</i>				33. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene 00 09279

Reg. No.

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09280

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BETTY JEFFRESS				2. Date of Death Month <u>March</u> Day <u>9</u> Year <u>2000</u>		3. Time of Death <u>1059pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Maryland General Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>210-16-9860</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>76</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Feb 28, 1924</u>		9. Birthplace (State or Foreign Country) <u>unknown</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>527 Halfmile Court</u>				10f. Zip Code <u>21201</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>black</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>unknown</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>unknown</u>			16b. Kind of Business/Industry <u>unknown</u>	
17. Father's Name (First, Middle, Last) <u>unknown</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>unknown</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Md General Hospital</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>827 Linden Ave Baltimore, MD 21201</u>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <u>in state</u>				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <u>Ronald S. Wad Director</u>				22. Name and Address of Facility <u>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Sepsis</u> Due to (or as a consequence of): <u>b. Pneumonia</u> Due to (or as a consequence of): <u>c. Respiratory Failure</u> Due to (or as a consequence of): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <u>Ana Maria Palhete MD</u>				29c. License number <u>89354</u>		29d. Date signed (Month, Day, Year) <u>3/9/00</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Ana Maria Palhete, M.D. 40 Maryland General Hospital</u>								
31. Date filed (Month, Day, Year) <u>MAR 22 2000</u>				32. Registrar's Signature <u>B. Sparks</u>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09281

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LYNDA

KULHA

2. Date of Death

March 5 2000

3. Time of Death

6:40AM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

190-50-3993

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR 5, 1958

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12549 Torquay Road

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

William A. Gigliotti

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Cox

19a. Informant's Name/Relationship (Type, Print)

Kerry Kulha/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12549 Torquay Rd. Ocean City, MD 21842

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 3/6/00

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. HEPATIC FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

SIX MONTHS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. ALCOHOL ABUSE

Due to (or as a consequence of):

TEN YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

RES-000

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MARCH 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARI ROBERTS, MD 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21237

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: # 26 PER MEO G781 3-22-2000 WR

State of Maryland / Department of Health and Mental Hygiene

00 09282

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Veronica Rose Kusterer				2. Date of Death Month Day Year March 18, 2000		3. Time of Death 4:10 am	
	4a. Facility Name (If not institution, give street and number) 5 Edmondson Ridge Road				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-05-8522	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	8. Date of Birth (Month, Day, Year) Feb. 11, 1919	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Randallstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 4140 Deer Park Road		10f. Zip Code 21133		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Warner Mather				18. Mother's Name (First, Middle, Maiden Surname) Rose Gonder			
	19a. Informant's Name/Relationship (Type, Print) Theresa Drechsler - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Edmondson Ridge Road; Catonsville, Maryland 21228			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State 3/21/2000 Sykesville, Maryland			
	21. Signature of Funeral Service Licensee  M00869		22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Chronic obstructive pulmonary disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Other Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) DAUGHTER'S RESIDENCE					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 	
	29c. License number A5872						29d. Date signed (Month, Day, Year) March 21 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harold B. B. 25 Main St Randallstown 21136 Maryland							
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09283

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Julia J. Kurt

2. Date of Death

Month
MARCH

Day

16 2000

3. Time of Death

11:43PM

4a. Facility Name (If not institution, give street and number)

Berlin Nursing and Rehabilitation Ctr.

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

217-01-3547

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 27, 1901

9. Birthplace (State or Foreign Country)

Hungary

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10001 Windstream Drive # 203

10f. Zip Code

21044

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Inspector

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Joseph Jendrick

18. Mother's Name (First, Middle, Maiden Surname)

Hanna Czet8

19a. Informant's Name/Relationship (Type, Print)

Irene M. Smith (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10001 Windstream Drive #203 Columbia, MD 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Mem. Park Cem. 3/21/00

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End Stage Senile Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA with Right Hemiplegia
Arteriosclerotic Cardiovascular Disease
Cardiomegaly

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

3-17-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 22 2000

Gemma B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09284

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JULIA MARIE LOSINSKI

2. Date of Death

March 18, 2000

3. Time of Death

5:50AM

4a. Facility Name (If not institution, give street and number)

HOSPICE OF BALTIMORE: GILCHRIST CENTER

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore County

Funeral
Director

5. Social Security Number

217-20-7368

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 9, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Anneslie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

609 Regester Avenue

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Prince Georges County

17. Father's Name (First, Middle, Last)

Edmund Anthony Losinski

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Barbara Tadeusiak

19a. Informant's Name/Relationship (Type, Print)

Regina H. Morin (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

783 Dividing Road, Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

3/21/2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.

6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ovarian Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W.A. Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

March 18, 2000

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

W.A. Riley GBMC 66701 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

Denise B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09285

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DEVRON M. LEGGE				2. Date of Death Month Day Year March 18, 2000		3. Time of Death 2259 pm			
	4a. Facility Name (If not institution, give street and number) Shock Trauma				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number P15-04-3915		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 16 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09-02-83	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1531 N. FULTON AVENUE				10f. Zip Code 21217		10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 TH GRADE College (1-4 or 5+) N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT			16b. Kind of Business/Industry SCHOOL			
	17. Father's Name (First, Middle, Last) JOHN LEGGE				18. Mother's Name (First, Middle, Maiden Surname) JOYCE BRISCOE					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JOYCE HORNER / MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 N. FULTON AVE., BALTO. MD. 21217					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		Date 3-24-00		20c. Location - City or Town, State BALTIMORE, MD			
	21. Signature of Funeral Service Licensee Vaughn C. Greene				22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound to chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 3-18-00		28b. Time of Injury 2229 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred. subject shot	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1531 Pennsylvania Ave							
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 19, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201									
State Registrar	31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09286

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN S. LANDBECK, SR.					2. Date of Death Month Day Year MARCH 8, 2000		3. Time of Death 2:15 AM			
	4a. Facility Name (If not institution, give street and number) 229 S. Rogers Street					4b. City, Town, or Location of Death Aberdeen		4c. County of Death Harford			
Funeral Director	5. Social Security Number 213-12-3532		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Oct 5, 1915		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent										
10a. State MD		10b. County Harford		10c. City, Town or Location Aberdeen				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 229 S. Rogers Street					10f. Zip Code 21001		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) administrator			16b. Kind of Business/Industry social security adm			
17. Father's Name (First, Middle, Last) Harry J. Landbeck					18. Mother's Name (First, Middle, Maiden Surname) Carrie S. Lambdin						
19a. Informant's Name/Relationship (Type, Print) John S. Landbeck, Jr./son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 S. Rogers Street Aberdeen, MD 21001						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director					22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)										3 YEARS	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										15 YEARS	
e. Chronic renal failure Due to (or as a consequence of):										4 YEARS	
b. Diabetes mellitus Type II Due to (or as a consequence of):											
c. Dilated cardiomyopathy Due to (or as a consequence of):											
d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred					28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Charles W. H. MD					29c. License number D31712		29d. Date signed (Month, Day, Year) 3/15/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES W. H. JR. 214 W. BELAIR AVE. ABERDEEN, MD 21001											
31. Date filed (Month, Day, Year) MAR 22 2000					32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 410-588-0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09287

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ida Lurie

2. Date of Death

March 19 2000

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-09-2841

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JAN. 13, 1912

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3800 OLD COURT ROAD #201-A

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JULIUS

18. Mother's Name (First, Middle, Maiden Surname)

COPLAN

REBECCA

COHEN

19a. Informant's Name/Relationship (Type, Print)

JULIE OKUN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 WOODCHESTER COURT - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH TFILOH CEMETERY

Date

3/21/00

20c. Location - City or Town, State

WOODLAWN, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple organ system failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Systemic inflammatory response syndrome

Due to (or as a consequence of):

10 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Diabetes mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

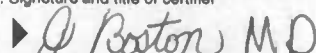
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D28462

29d. Date signed (Month, Day, Year)

March 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J Boston, M.D. - Northwest Hospital Center Randallstown Maryland

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09288

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Andrea McDaniel				2. Date of Death Month March Day 17 Year 2000				3. Time of Death 14:30		
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore City				4c. County of Death N/A		
Funeral Director	5. Social Security Number 218 29 7276		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 9 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 22, 1990		9. Birthplace (State or Foreign Country) Maryland		
	10a. State Maryland				10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 3301 Ludgate Road				10f. Zip Code 21215				10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd grade College (14 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT				16b. Kind of Business/Industry Elementary SCHOOL				
	17. Father's Name (First, Middle, Last) ARNDRAY Mc DANIEL				18. Mother's Name (First, Middle, Maiden Surname) DANETTE A. GAYLE						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Marion Tisdale / Grandmother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3301 Ludgate Road Baltimore, Maryland 21215						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DRUID RIDGE Cemetery				20c. Location - City or Town, State 3-24-2000 Pikesville, Maryland				
	21. Signature of Funeral Service Licensee Gary Harris				22. Name and Address of Facility CHATHAM - HARRIS F.H. 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21215						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Brainstem glioma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death 6 months		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier MD PhD				29c. License number D47025				29d. Date signed (Month, Day, Year) March 20, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen R. Chen 600 North Wolfe Street Baltimore, Maryland 21287											
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09289

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM MURPHY				2. Date of Death Month Day Year MARCH 3, 2000		3. Time of Death 3:21P.M.																																					
	4a. Facility Name (If not institution, give street and number) 405 S.CANTON AVE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A																																					
Funeral Director	5. Social Security Number unknown		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) unknown Yrs.		8. Date of Birth (Month, Day, Year) unknown																																					
	Usual Residence of Decedent		10a. State unknown		10b. County unknown		10c. City, Town or Location unknown																																					
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No unknown		10e. Street and Number unknown		10f. Zip Code unknown		10g. Citizen of What Country? USA																																						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white																																						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (14 or 5+) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown																																								
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown																																								
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201																																								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State																																								
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201																																								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																												
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">a. Narcotic and Ethanol Intoxication</td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="7">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Narcotic and Ethanol Intoxication							Due to (or as a consequence of):							Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):							c. Due to (or as a consequence of):							d. Due to (or as a consequence of):						
Immediate Cause (Final disease or condition resulting in death)	a. Narcotic and Ethanol Intoxication																																											
	Due to (or as a consequence of):																																											
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):																																										
		c. Due to (or as a consequence of):																																										
d. Due to (or as a consequence of):																																												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																												
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																												
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																												
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE																																										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury Month Day Year Found: 3/3/2000		28b. Time of Injury Hour: 3:10P M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																						
28d. Describe how injury occurred Unknown		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found in house																																										
28f. Location (Street and Number or Rural Route Number, City or Town, State) 405 S. Canton Ave. Balto. City, MD.																																												
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																												
29b. Signature and title of certifier Joseph Pestaner, MD				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 4, 2000																																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201																																												
31. Date filed (Month, Day, Year) MAR 2 2000		32. Registrar's Signature S. Sparks																																										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09290

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sharon K. Michael</i>				2. Date of Death Month <i>3</i> Day <i>17</i> Year <i>2000</i>		3. Time of Death <i>6:10 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>North Arundel Hospital</i>				4b. City, Town, or Location of Death <i>Glen Burnie</i>		4c. County of Death <i>Anne Arundel</i>	
Funeral Director	5. Social Security Number <i>218-52-8283</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>50</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Sept. 12, 1949</i>	
	9. Birthplace (State or Foreign Country) <i>Huntington, West Virginia</i>							
Usual Residence of Decedent								
10a. State <i>MD</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Gambrills</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>2621 Brickhead Road</i>				10f. Zip Code <i>21054</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>Merle Campbell</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Opal Johnston</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Joseph A. Michael/Husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2621 Brickhead Road, Gambrills, MD 21054</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		Date <i>3/21</i> <i>2000</i>		20c. Location - City or Town, State <i>Baltimore, MD</i>	
21. Signature of Funeral Service Licensee <i>Michael P. Kutta</i>				22. Name and Address of Facility <i>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. myocardial infarction</i> Due to (or as a consequence of): <i>b. cardiomyopathy</i> Due to (or as a consequence of): <i>c. end stage renal disease</i> Due to (or as a consequence of): <i>d.</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Dr. Y. Choi</i>				29c. License number <i>D38547</i>		29d. Date signed (Month, Day, Year) <i>3/17/00</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dave Y. Choi 7845 Oakwood Rd #205, Glen Burnie, MD 21061</i>								
31. Date filed (Month, Day, Year) <i>MAR 22 2000</i>			32. Registrar's Signature <i>B. Sparks</i>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09291

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM MURPHY.				2. Date of Death Month Day Year MARCH 17 TH 2000		3. Time of Death 3:20 AM		
	4a. Facility Name (If not Institution, give street and number) NORTHWEST HOSPITAL CENTER				4b. City, Town, or Location of Death RANALLSTOWN		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 216-34-2697		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) MAY 22, 1937		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Reisterstown		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10a. Street and Number 641 Glynock Place		10f. Zip Code 21131		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Limousine Service		17. Father's Name (First, Middle, Last) Lawrence Murphy		18. Mother's Name (First, Middle, Maiden Surname) Johanna Stromburg	
19a. Informant's Name/Relationship (Type, Print) Michael A. Murphy/son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 Sacred Heart Lane Glyndon, MD 21136		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Bartholomew's Cemetery		20c. Location - City or Town, State Manchester, MD	
21. Signature of Funeral Service Licensee Dawn F. McDonald		22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Baltimore, MD 21228		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CONGESTIVE CARDIOMYOPATHY		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier Dawn F. McDonald PHYSICIAN		29c. License number D 42723		29d. Date signed (Month, Day, Year) MARCH 17 TH 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVVERAVALI M HARISH. NORTHWEST HOSPITAL CENTER RANALLSTOWN MD 21133		31. Date filed (Month, Day, Year) MARCH 22 2000		32. Registrar's Signature G. Sparks		State Registrar			

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09292

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albertina Manuel				2. Date of Death Month Day Year March 20 2000				3. Time of Death 4:45 PM	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare - Severna Park				4b. City, Town, or Location of Death Severna Park				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 105-22-8391		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) DEC 8, 1918		9. Birthplace (State or Foreign Country) Cuba	
	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severna Park				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 24 Truck House Road				10f. Zip Code 21146				10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Cuban				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry Education	
	17. Father's Name (First, Middle, Last) Manuel Ochoa				18. Mother's Name (First, Middle, Maiden Surname) Gloria Sabourit					
	19a. Informant's Name/Relationship (Type, Print) Gloria E. Brown/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1272 Holmespun Dr., Pasadena, MD 21122					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 3/21/00				20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee Thomas Gregor				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Sepsis Due to (or as a consequence of): b. Aspiration Pneumonia Due to (or as a consequence of): c. Cerebrovascular Accident Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5 days 7 days 3 years									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier John F. Hoome, M.D. Attorney Physician				29c. License number D52728		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John F. Hoome, M.D. 479 Juniper Hill Rd. # 304 Severna Park, MD 21146				31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature B. Sparks		
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature B. Sparks				29d. Date signed (Month, Day, Year) March 20, 2000		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09293

Amended Item#29d perPhyG781 3/22/2000 EW Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel Nelson

2. Date of Death

Month
MarchDay
7Year
2000

3. Time of Death

10:35 am

4a. Facility Name (If not institution, give street and number)

Augsburg Lutheran Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

124-18-8085

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 22, 1911

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

2506 Windy Side Court

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Christian Christiansen

18. Mother's Name (First, Middle, Maiden Surname)

Christina Gustovsen

19a. Informant's Name/Relationship (Type, Print)

Charles E. Nelson (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2506 Windy Side Court, Odenton, MD 21113

20a. Method of Disposition

2 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

The Evergreens Cemetery

Date

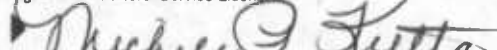
03/10/

2000

20c. Location - City or Town, State

Brooklyn, NY

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e.

Congestive Heart Failure

mos

Due to (or as a consequence of):

f.

ischemic cardiomyopathy

7 mos

Due to (or as a consequence of):

g.

coronary disease

7 mos

Due to (or as a consequence of):

h.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D37573

29d. Date signed (Month, Day, Year)

March 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. P. Bell, MD 7220 Park Heights Ave Baltimore MD 21208

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature



State

Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09294

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVA NICHOLAS				2. Date of Death Month Day Year MARCH 18, 2000				3. Time of Death 8:00 AM			
	4a. Facility Name (If not institution, give street and number) 8018 CRAINMONT DRIVE				4b. City, Town, or Location of Death GLEN BURNIE				4c. County of Death ANNE ARUNDEL			
Funeral Director	5. Social Security Number 216.44.5184		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) 10/30/1944		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 8018 CRAINMONT DRIVE				10f. Zip Code 21061		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME				
	17. Father's Name (First, Middle, Last) Harry Pierman				18. Mother's Name (First, Middle, Maiden Surname) Josephine Unknown							
	19a. Informant's Name/Relationship (Type, Print) Hurley Nicholas - husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8018 Crainmont Drive, Glen Burnie, MD 21061							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 3/20/00		20c. Location - City or Town, State Baltimore, MD					
	21. Signature of Funeral Service Licensee <i>Kelly Gregory Fink</i> KELLY GREGORY FINK				22. Name and Address of Facility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Carcinoma of the Nasal Mucosa with Direct Extension into the Brain</i> Due to (or as a consequence of): b. <i>into the Brain</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Primary Breast Carcinoma</i> <i>Primary Renal Cell Carcinoma</i> <i>Primary Biliary Cirrhosis, Autoimmune Hepatitis</i>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Erik L. Russell MD</i>		29c. License number D43623		29d. Date signed (Month, Day, Year) 3/29/00						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Erik L. Russell, M.D., 795 Aquahart Road, Suite 203, Glen Burnie, MD 21061												
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature <i>B. Spack</i>										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#7 perFHG781 3/22/2000 EW

Certificate of Death

Reg. No.

00 09295

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janet Nelson

2. Date of Death

Month Day Year
MARCH 19 2000

3. Time of Death

2:45A

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

218-32-5439

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

72 73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12 11 27

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Millersville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

812 Richard Tongue Drive

10f. Zip Code

21108

10g. Citizen of What Country?

USA.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietician

16b. Kind of Business/Industry

Crownsville State Hospital

17. Father's Name (First, Middle, Last)

Richard W. Tongue

18. Mother's Name (First, Middle, Maiden Surname)

Alveta

19a. Informant's Name/Relationship (Type, Print)

Larry Nelson - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

812 Richard Tongue Drive Millersville, Md. 21108

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Annapolis Memorial Garden 3-23-2000 Annapolis, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jeff Nelson

22. Name and Address of Facility

Hauener Hicks F/H 1925 Forest Drive Annapolis, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DEHYDRATION

Due to (or as a consequence of):

c. HYPOSPASIS

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeff Nelson

29c. License number

MD D45149

29d. Date signed (Month, Day, Year)

MARCH 19 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONABAYO, 301 HOSPITAL DRIVE GLEN BURNIE MD 21061.

State
Registrar

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

Jennifer G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09296

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Benjamin Oden				2. Date of Death Month 03 Day 19 Year 2000				3. Time of Death 7:10 p.m.	
	4a. Facility Name (If not institution, give street and number) Mariner Health of North Arundel				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel Co.	
Funeral Director	5. Social Security Number 217-07-1715		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) 01 17 1908		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Anne Arundel Co.		10c. City, Town or Location Glen Burnie	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 334 Wellham Avenue		10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Collegia (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Masonry Contractor				16b. Kind of Business/Industry Construction	
	17. Father's Name (First, Middle, Last) Benjamin Oden				18. Mother's Name (First, Middle, Maiden Summe) Rachel Henson					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Odessa Flemming/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 334 Wellham Avenue, Glen Burnie, Maryland 21060					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park		Date 3/23/00		20c. Location - City or Town, State Catonsville, Md.			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee				22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Md. 21217					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. ASPIRATION PNEUMONITIS Due to (or as a consequence of): b. CEREBRAL INFARCT Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. Approximate Interval Between Onset and Death DAYS WEEKS YEARS									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE CHRONIC RENAL FAILURE VENTRICULAR TACHYCARDIA				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D19991				29d. Date signed (Month, Day, Year) 3/21/2000	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier M.D.				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL ROSS, M.D., SUITE 500 200 W. NORTH AVENUE GLEN BURNIE MARYLAND 21061					
	31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks							

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09297

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANGELA OUTEDA

2. Date of Death

Month Day Year
MARCH 17 2000

3. Time of Death

6:50 pm

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

067-01-2111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 19, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

707 Maiden Choice Lane Apt. 3102

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Fabric Industry

17. Father's Name (First, Middle, Last)

Antonio Outeda

16. Mother's Name (First, Middle, Maiden Surname)

Petra Tie

19e. Informant's Name/Relationship (Type, Print)

Carolyn A. Foulkes/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2106 Dobler Avenue Baltimore, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc.

Data

3/18/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. HYPERCARBIC HYPOXIC RESPIRATORY FAILURE

DAYS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. PULMONARY HYPERTENSION

YEARS

Due to (or as a consequence of):

c. MITRAL REGURGITATION

YEARS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lucia Palladino MD

29c. License number

P 116 99

29d. Date signed (Month, Day, Year)

MARCH 17 - 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUCIA PALLADINO 900 CATON AVE. BALTIMORE

State
Registrar

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

NAME Outeda, Angela

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09298

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Mitchell Perkins, Sr.				2. Date of Death Month Day Year MARCH 20 2000		3. Time of Death 10:45 PM	
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 090-14-2147	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 23, 1916	9. Birthplace (State or Foreign Country) Florida	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Lutherville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 89 Blondell Court			10f. Zip Code 21093		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Representative		16b. Kind of Business/Industry Clothing			
	17. Father's Name (First, Middle, Last) Cecil Robert Perkins				18. Mother's Name (First, Middle, Maiden Surname) Vada Augusta DeLoache			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. John T. Perkins, Sr. (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Cross Falls Circle Sparks, Maryland 21152			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Hill Cemetery		Date 3/24/2000		20c. Location - City or Town, State Towson Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. PROBABLE PULMONARY EMBOLISM Due to (or as a consequence of): c. Liver Cancer Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 15 minutes Several hours 9 months							
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Matilda H. Sparks, M.D.		29c. License number D26250	
	29d. Date signed (Month, Day, Year) 3/21/2000							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATILDA H. SPARKS, 6701 N. CHARLES ST., BALTO, MD 21204							
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09299

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth S. Propst				2. Date of Death Month Day Year March 20, 2000				3. Time of Death 2:30 P.M.	
	4a. Facility Name (If not Institution, give street and number) 7006 Bristol Place				4b. City, Town, or Location of Death Sykesville				4c. County of Death Carroll	
Funeral Director	5. Social Security Number 245-32-6968		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Nov. 19, 1926		9. Birthplace (State or Foreign Country) North Carolina		Usual Residence of Decedent		10a. State Maryland		10b. County Carroll	
To Be Completed by Funeral Director	10c. City, Town or Location Sykesville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7006 Bristol Place		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier		16b. Kind of Business/Industry Acme Foods			
	17. Father's Name (First, Middle, Last) Hugh Reinhardt				18. Mother's Name (First, Middle, Maiden Surname) Hannie Hollar					
	19a. Informant's Name/Relationship (Type, Print) Mrs. Cathy Granger - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7006 Bristol Place Sykesville, MD 21784					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 3/21/00		20c. Location - City or Town, State Woodlawn, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease				Due to (or as a consequence of):				Approximate Interval Between Onset and Death 5 yrs	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				Due to (or as a consequence of):					
	Due to (or as a consequence of):				Due to (or as a consequence of):					
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number 045570	
					29d. Date signed (Month, Day, Year) 3/21/00					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1380 Program Way Suite 112 Eldersburg, MD 21784 Glenn Herman M.D.									
	31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITME: #1 PER MD G784 6-22-00 WR.

Certificate of Death

Reg. No.

00 09300

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NANNIE J. PRUNELLA Nannie I. Prunella				2. Date of Death Month Day Year March 20 2000			3. Time of Death 1:00P.M.		
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center Baltimore				4b. City, Town, or Location of Death			4c. County of Death		
Funeral Director	5. Social Security Number 412-18-5402		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) December 22, 1919		9. Birthplace (State or Foreign Country) Tennessee	
	Usual Residence of Decedent									
10a. State PA.		10b. County Clearfield		10c. City, Town or Location Winburne				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number P.O. Box 344				10f. Zip Code 16879			10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide			16b. Kind of Business/Industry Medical			
17. Father's Name (First, Middle, Last) James Vanzant					18. Mother's Name (First, Middle, Maiden Summe) Leona					
19a. Informant's Name/Relationship (Type, Print) Georgianne Dorunda					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Hickory Lane Austintown, Ohio 44515					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Messiah Baptist Cemetery			20c. Location - City or Town, State 3/24 Kylertown, Pennsylvania				
21. Signature of Funeral Service Licensee Michael P. Marzullo					22. Name and Address of Facility Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland 21155					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Dementia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Esophageal stricture Paraplegia Atrial fibrillation										
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Thomas Finucane MD					29c. License number D24334			29d. Date signed (Month, Day, Year) March 21, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Finucane Johns Hopkins Geriatrics Center										
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09301

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor K. Patterson

2. Date of Death

March 17 2000

3. Time of Death

4:40 am

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Spa Creek

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

213-12-2556

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

April 19, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1008 Tallwood Road, Apt. 1A

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1942-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Kordecki

18. Mother's Name (First, Middle, Maiden Surname)

Atolia Poniatowski

19a. Informant's Name/Relationship (Type, Print)

Andrea Harrison (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1601 Virginia Avenue, Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date
03/18/
2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

▶ *Patricia J. Arnold*

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Nephrosclerosis

b.

Due to (or as a consequence of):

HTN

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

4 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

1 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

▶ *G. Sprase*

29c. License number

J32036

29d. Date signed (Month, Day, Year)

3/17/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gay J. Sprase 2102 S. Darnley Ave. Chert. MD 21619

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

*Genevieve G. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09302

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JANE Purkins				2. Date of Death Month MARCH Day 19 Year 2000		3. Time of Death 18 20	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 217-24-3184		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 1, 1926	
	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 412 MILTON AVE.				10f. Zip Code 21061		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER		16b. Kind of Business/Industry EDUCATION			
	17. Father's Name (First, Middle, Last) GEORGE CARTER				18. Mother's Name (First, Middle, Maiden Surname) MINNIE BROHAWN			
	19a. Informant's Name/Relationship (Type, Print) JOHN H. PURKINS/HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 MILTON AVE. GLEN BURNIE, MD 21061			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PK.		20c. Location - City or Town, State 2000 GLEN BURNIE, MD			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. ATRIAL FIBRILLATION Due to (or as a consequence of): c. CONGESTIVE HEART FAILURE Due to (or as a consequence of): d. CORONARY ARTERY DISEASE							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES HYPERTENSION							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined							
Medical Certification: To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)							
	28b. Time of Injury M							
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Alain Bertoni MD</i>				29c. License number 1D0053444		29d. Date signed (Month, Day, Year) MARCH 19, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alain Bertoni M.D. 5601 Loch Raven Blvd BALTIMORE MD 21239								
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature <i>[Signature]</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09303

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carl Frank Peters, Sr.					2. Date of Death Month Day Year March 20, 2000		3. Time of Death 3:05 AM		
	4a. Facility Name (If not institution, give street and number) 2710 Kirkleigh Road					4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 215-18-9958		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) May 1, 1922		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 2710 Kirkleigh Road				10f. Zip Code 21222		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 2 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Asst. General Superintendent			16b. Kind of Business/Industry Steel Industry				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Daniel A. Peters					18. Mother's Name (First, Middle, Maiden Surname) Theresa J. Gindra				
	19a. Informant's Name/Relationship (Type, Print) Carl F. Peters, Jr. (Son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Kirkleigh Road Dundalk, Maryland 21222				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cemetery			20c. Date 3/23/2000		20d. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>SQUAMOUS CELL LUNG CANCER</u> Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 year	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC LUNG DISEASE, HISTORY OF</u> <u>(R) PNEUMONECTOMY 10 years ago.</u>									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 					29c. License number 029197		29d. Date signed (Month, Day, Year) March 20, 2000		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. M. NORTON, MD 9101 FRANKLIN SQUARE DR BALTO, MD 21237									
	31. Date filed (Month, Day, Year) MAR 22 2000					32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09304

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM ROBERTS SR.						2. Date of Death Month Day Year March 15 2000		3. Time of Death 11:40 am		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center						4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 577-42-9729		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 10, 1934		9. Birthplace (State or Foreign Country) Maryland		
	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Edgewater		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 3916 River Club Drive		10f. Zip Code 21037		10g. Citizen of What Country? USA							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Sheet Metal & A/C							
17. Father's Name (First, Middle, Last) Marvin Roberts						18. Mother's Name (First, Middle, Maiden Surname) Helen Long					
19a. Informant's Name/Relationship (Type, Print) Margaret M. Roberts (Wife)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3916 River Club Drive, Edgewater, MD 21037					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 03/20 2000		20c. Location - City or Town, State Baltimore, MD					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COPD Due to (or as a consequence of): b. COR PULMONALE Due to (or as a consequence of): c. STROKE Due to (or as a consequence of): d. ATRIAL FIBRILLATION										Approximate Interval Between Onset and Death UNKNOWN UNKNOWN 6 DAYS UNKNOWN	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASBESTOSIS						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) N/A		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29c. Signature and title of certifier 		29d. License number D39037		29e. Date signed (Month, Day, Year) 3-15-00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOUGLAS S MITCHELL, ANNE ARUNDEL MEDICAL CENTER, ANNAPOLIS											
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature 									

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

00 09305

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Keith Rogers					2. Date of Death Month Day Year MARCH 18, 2000			3. Time of Death 2:15 A.M.						
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER					4b. City, Town, or Location of Death ANNAPOLIS			4c. County of Death ANNE ARUNDEL						
Funeral Director	5. Social Security Number 217-19-8766		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 18 Yrs.		8. Date of Birth (Month, Day, Year) June 16, 1981		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent														
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Shady Side				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 4911 Idlewilde Road					10f. Zip Code 20764			10g. Citizen of What Country? USA							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student			16b. Kind of Business/Industry Education							
17. Father's Name (First, Middle, Last) Thomas Edward Rogers					18. Mother's Name (First, Middle, Maiden Sumame) Lauri Annette Leonard										
19a. Informant's Name/Relationship (Type, Print) Lauri A. Rogers (Mother)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4911 Idlewilde Road, Shady Side, MD 20764										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Woodfield Cemetery			20c. Date 03/22 2000		20d. Location - City or Town, State Galesville, MD							
21. Signature of Funeral Service Licensee <i>Michael D. Litta</i>					22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>MULTIPLE INJURIES</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death —					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) 3/18/00		28b. Time of Injury 1243 A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred DRIVER in motor vehicle accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) SHADYSIDE, MD						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier <i>J.M. [Signature]</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 19, 2000	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) JACK M. TRUS, M.D. 111 Penn Street, Baltimore, Maryland 21201															
31. Data filed (Month, Day, Year) MAR 22 2000			32. Registrar's Signature <i>[Signature]</i>												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09306

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELLEN VIRGINIA RICHARDSON				2. Date of Death Month Day Year March 18, 2000		3. Time of Death 10:00 AM	
	4a. Facility Name (If not institution, give street and number) 3501 St. Paul Street #941				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 405-38-1896	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 23, 1916		9. Birthplace (State or Foreign Country) Kentucky
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3501 St Paul Street, Apt 941				10f. Zip Code 21218		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker			16b. Kind of Business/Industry State of Maryland	
17. Father's Name (First, Middle, Last) Irvin Benton Richardson				18. Mother's Name (First, Middle, Maiden Surname) Lottie Reader Compton				
19a. Informant's Name/Relationship (Type, Print) John H. Sommerville, Esq. (Per. Rep)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 St Paul Street, Baltimore, Maryland				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Ivy Hill Cemetery		20c. Location - City or Town, State 3/29/00 Hardinburg, KY		
21. Signature of Funeral Service Licensee Martin D. Lawson				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Aortic sclerosis Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Osteoporosis Due to (or as a consequence of): d. TIA / old strokes								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Marguerite Moran M.D.		29c. License number D000 8093		29d. Date signed (Month, Day, Year) 3/21/00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marguerite Moran, M.D., 200 E. 33rd Street, Suite 265, Baltimore, MD 21218								
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature B. Sparks				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #26 PER MEO G781 3-22-2000 WR. State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

00 09307

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elmer Reichenbach				2. Date of Death Month Day Year March 17, 2000		3. Time of Death 6:54pm	
	4a. Facility Name (If not institution, give street and number) North West Hospital Center				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 197-05-3035	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 2, 1919		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent				10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Woodmoor		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7209 Brompton Road				10f. Zip Code 21207		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		College (1-4 or 5+) -0-		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fuel & Trucking Company		16b. Kind of Business/Industry Self-Employed	
	17. Father's Name (First, Middle, Last) John Henry Reichenbach				18. Mother's Name (First, Middle, Maiden Surname) Margaret Elizabeth Bowers			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary Carter - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8622 Allenswood Road; Randallstown, Maryland 21133			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		Date 3/20/2000		20c. Location - City or Town, State Sykesville, Maryland	
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier [Signature]		29c. License number D31296		29d. Date signed (Month, Day, Year) March 17, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rhonda Richards, MD Northwest Hospital Center							
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature [Signature]						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09308

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Archie

Reed

2. Date of Death

March 17, 2000

Day Year

3. Time of Death

10:12

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-40-0109

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-14-40

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1924 DIVISION STREET

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
9TH GRADECollege (14 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MILL WORKER

16b. Kind of Business/Industry

MILL

17. Father's Name (First, Middle, Last)

ARCHIE REED, SR.

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE COOPER

19a. Informant's Name/Relationship (Type, Print)

TANYA REED DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

413 N. MONTFORD AVE., BALTO. MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESTERN STAR

Date

3-24-00

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NAT'L PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Polymicrobial Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

02 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Squamous Cell Carcinoma of the left Hypopharynx

Due to (or as a consequence of):

07 months

c. Squamous Cell Carcinoma of the Right Oral Cavity

Due to (or as a consequence of):

07 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Congestive Heart Failure

Gout

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Nelson

29c. License number

RES-0000

29d. Date signed (Month, Day, Year)

3/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Nelson JH 600 N. Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

S. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09309

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EARL ROSE				2. Date of Death Month 3 Day 20 Year 00		3. Time of Death 845 A	
	4e. Facility Name (If not institution, give street and number) Genesis Eldercare - Catonsville Commons				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 228-44-0674		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) MAY 28, 1935	
	9. Birthplace (State or Foreign Country) Virginia		10e. State MD		10b. County N/A		10c. City, Town or Location Brooklyn Park	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3818 Leadenhall Street		10f. Zip Code 21225		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dry Wall		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Hadley Rose				18. Mother's Name (First, Middle, Maiden Surname) Bertha Yates			
	19a. Informant's Name/Relationship (Type, Print) Mark W. Rose/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Glenlea Dr., Glen Burnie, MD 21060			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Location - City or Town, State Baltimore, MD		20d. Date 3/21/00	
	21. Signature of Funeral Service Licensee Thomas Gregor				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Head and Neck Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Thrombosis of Internal Jugular Vein Herpes Zoster Skin Infection History of Oropharyngeal Squamous Cell Cancer							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Shalini Tewari MD				29c. License number D52671		29d. Date signed (Month, Day, Year) March 20, 2000	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Shalini Tewari MD 1838 Greene Tree Road / Suite 300 / Pikesville, MD 21208							
	31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09310

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Solveig Johnson Seltzer

2. Date of Death

Month
MarchDay
21Year
2000

3. Time of Death

1:30 A.M.

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-48-5919

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan. 09 1916

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

902 West University Pkwy.

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Artist

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Isacc Richard Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Alice Elizabeth Anderson

19a. Informant's Name/Relationship (Type, Print)

Ms. Dika A. Seltzer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

902 West University Pkwy. Baltimore, MD. 21210

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Co.

Date

3-22-00

20c. Location - City or Town, State

Towson, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Dementia

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DH3725

29d. Date signed (Month, Day, Year)

3/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 201-104 Back River Neck Rd Baltimore MD 21221

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

SELTZER, SOLVEIG

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09311

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Lillian Stout						2. Date of Death Month Day Year March 20, 2000		3. Time of Death 5:36 PM		
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-28-4787		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) May 28, 1932		9. Birthplace (State or Foreign Country) Baltimore, Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1820 Wadsworth Way		10f. Zip Code 21239		10g. Citizen of What Country? United States of America			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) John Julius Drost		18. Mother's Name (First, Middle, Maiden Surname) Lillian Kozac			
19a. Informant's Name/Relationship (Type, Print) Mr. Charles Henry Stout (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Wadsworth Way Baltimore, Maryland 21239		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corporation		20c. Location - City or Town, State Towson, Maryland			
21. Signature of Funeral Service Licensee Jeffrey L. Gair		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ANOXIC ENCEPHALOPATHY Due to (or as a consequence of): b. INTRACRANIAL HEMORRHAGE Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dua MD		29c. License number P 11400		29d. Date signed (Month, Day, Year) MARCH 20 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUA, GOOD SAMARITAN HOSPITAL, BALTIMORE MD 21239		31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature Benita B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09312

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth P. Schafer					2. Date of Death Month Day Year March 20, 2000		3. Time of Death 10:10 PM								
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare Perring Parkway					4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore								
Funeral Director	5. Social Security Number 218-40-1466		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 21, 1908		9. Birthplace (State or Foreign Country) Maryland							
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Parkville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	10e. Street and Number 3417 Putty Hill Ave.				10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.									
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home									
	17. Father's Name (First, Middle, Last) Charles Ament					18. Mother's Name (First, Middle, Maiden Surname) Ruth Tyson										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. John Schafer/Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2417 Perring Woods Rd. Parkville, Md. 21234										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 8/24/00		20c. Location - City or Town, State Baltimore, Maryland								
	21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204										
	23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Deserudin, Alzheimer</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>many years</i>															
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Abdominal aortic aneurysm, Hypertension DVT DVT DVT</i>															
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>					29c. License number D 54518					29d. Date signed (Month, Day, Year) 3/21/00					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3007 Wenden Parkway Baltimore MD 21214															
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) MAR 22 2000					32. Registrar's Signature <i>[Signature]</i>										

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09313

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRIETTE R. STEIN

2. Date of Death

FEBRUARY 22, 2000 6:58 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-07-8514

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09/30/1914

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28 Allegheny Avenue

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Malcolm L. Ruth

18. Mother's Name (First, Middle, Maiden Surname)

Beulah Folks

19a. Informant's Name/Relationship (Type, Print)

Harriette Kirchenbauer-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 Country Woods Dr., Bear, DE 19701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem.Grdns.2/24/00 Timonium, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dennis C. Carroll per DVR

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

PROBABLE PULMONARY EMBOLUS

Approximate Interval Between Onset and Death

HOURS

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

Elisabete K. Lucas MD

29d. License number

D35817

29e. Date signed (Month, Day, Year)

March 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH LUCAS M.D. 660 KENILWORTH DRIVE SUITE 202 TOWSON, MD. 21204

State
Registrar

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09314

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARRY CASPER STENGEL, JR.				2. Date of Death Month Day Year MARCH 20, 2000 10:00 AM		3. Time of Death																	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore																	
Funeral Director	5. Social Security Number 218-14-6013	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 30, 1922	9. Birthplace (State or Foreign Country) Md.																	
	Usual Residence of Decedent																							
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore	10c. City, Town or Location Long Green			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
	10e. Street and Number 8 Windy Hill Rd.			10f. Zip Code 21092		10g. Citizen of What Country? USA																		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW-II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver			16b. Kind of Business/Industry Genstar																		
	17. Father's Name (First, Middle, Last) Harry C. Stengel, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Katherine Inez Cordle																			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Sharon Eyre/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5325 Glen Arm Rd. Glen Arm, Md. 21057																				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial		20c. Date 3/24/00		20d. Location - City or Town, State Timonium, Md.																	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204																			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>ACUTE PNEUMONIA</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>CHRONIC PNEUMONITIS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td>TO YEARS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	ACUTE PNEUMONIA	Approximate Interval Between Onset and Death	Due to (or as a consequence of):		b.	CHRONIC PNEUMONITIS	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.		TO YEARS	d.	
Immediate Cause (Final disease or condition resulting in death)	a.	ACUTE PNEUMONIA	Approximate Interval Between Onset and Death																					
	Due to (or as a consequence of):																							
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	Due to (or as a consequence of):																							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.		TO YEARS																					
	d.																							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																	
							24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																	
			28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)																	
			28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																							
State Registrar	29b. Signature and Title of certifier Steven R. Axe M.D.				29c. License number D34543		29d. Date signed (Month, Day, Year) 3-24-00																	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN R. AXE M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204																							
	31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks																					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09315

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD MILTON SKABLISKY

2. Date of Death

Month

Day

Year

February 28, 2000 6:15am

3. Time of Death

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

217-34-4851

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

2-23-1938

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

CROWNSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

809 SCENIC PLACE

10f. Zip Code

21032

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 3 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SERVICE MANAGER

16b. Kind of Business/Industry

AIR CONDITIONER & REFRIGERATOR

17. Father's Name (First, Middle, Last)

EDWARD JOSEPH SKABISKY

18. Mother's Name (First, Middle, Maiden Surname)

EVELYN ROGUSKY

19a. Informant's Name/Relationship (Type, Print)

SHERRY SKABISKY (WHITE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

809 SCENIC PLACE CROWNSVILLE, MD 21032

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

3/2/00

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

SHANNON M. MCGARRIGLE Per DVR

22. Name and Address of Facility

AMBROSE FUNERAL HOME OF LANSDOWNE

2719 HAMMONDS FERRY ROAD LANSDOWNE, MD 21217

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Eosinophilic Granuloma of Lung

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

one week

Four Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pancreatic Cancer, Stroke, Cardiomyopathy

Porcine Aortic valve for Aortic Stenosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D48006

29d. Date signed (Month, Day, Year)

March 20th, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOFI BOATEY, 301 Hosp. Dr, Glen Burnie, MD 21061

State
Registrar

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

[Signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09316

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald L. Sachs, Sr.				2. Date of Death Month MARCH Day 17 Year 2000		3. Time of Death 11:13 AM	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-28-4642		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) March 10, 1931	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 413 Brownell Road		10f. Zip Code 21220		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (14 or 5+) College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Mechanic		16b. Kind of Business/Industry Heating & Air Cond.				
17. Father's Name (First, Middle, Last) Andrew Sachs				18. Mother's Name (First, Middle, Maiden Surname) Eva (Surname Unknown)				
19a. Informant's Name/Relationship (Type, Print) Mrs. Mary C. Sachs (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Brownell Rd., Baltimore, MD 21220				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Gard.		20c. Date 3/21/00		20d. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Mark T. Zygorski		22. Name and Address of Facility Schmunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONTACT GUNSHOT WOUND TO HEAD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death Brief						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 3/17/00		28b. Time of Injury 10:30 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred SELF-INFLICTED GUNSHOT WOUND		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 413 BROWNELL ROAD BALTIMORE, MD				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J.M. TINS		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 18, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09317

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARA MARGUERITE SEIDLING				2. Date of Death Month Day Year MARCH 19 2000		3. Time of Death 5:10 A	
	4a. Facility Name (If not institution, give street and number) 809 N. GLOVER ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-44-0906		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 31, 1913	
	9. Birthplace (State or Foreign Country) MARYLAND							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 809 N. GLOVER STREET				10f. Zip Code 21205		10g. Citizen of What Country? U. S. A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAITRESS		16b. Kind of Business/Industry CATERING			
	17. Father's Name (First, Middle, Last) GEORGE SEIDLING				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE MARY REJZEK			
	19a. Informant's Name/Relationship (Type, Print) MRS. KATHLEEN P. FARRAN (Friend)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 N. GLOVER STREET, BALTIMORE, MARYLAND 21205			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY		Date 3/21/00		20c. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC. 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213			
	23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMER'S DISEASE							
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? INSPECTION				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 19, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201							
	State Registrar	31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09318

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lynwood K. Springs

2. Date of Death

March 21, 2000

3. Time of Death

12:04 am

4a. Facility Name (If not Institution, give street and number)

Charles town Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-68-7210

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 31, 1909

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

719 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas

Kidd

18. Mother's Name (First, Middle, Maiden Surname)

Fannie

Clapp

19a. Informant's Name/Relationship (Type, Print)

Mary Jane Koss- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

957 Washington Street, Spencerport, NY 14559

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crem. Ctr, LLC

Date

3/22/2000

20c. Location - City or Town, State

Stevensville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Singleton Funeral Home, PA

1 Second Avenue, SW, Glen Burnie, MD 21061

23a. Path: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Andres Salazar MD

29c. License number

D 51051

29d. Date signed (Month, Day, Year)

March 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Lynwood Springs
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09319

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARYLAND WERKING SLADE				2. Date of Death Month Day Year March 16, 2000		3. Time of Death 1:45 P.M.	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-10-1698		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 8, 1917	
	9. Birthplace (State or Foreign Country) Ohio		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Rodgers Forge	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10a. Street and Number 104 Murdock Road		10f. Zip Code 21212		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary		16b. Kind of Business/Industry City Schools			
	17. Father's Name (First, Middle, Last) Charles Raymond Werking				18. Mother's Name (First, Middle, Maiden Surname) Mazie Bolden			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Marvia Slade Perreault (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Murdock Road Baltimore, Maryland 21212			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. Location - City or Town, State Pikesville, Maryland		20d. Date 3-21-2000	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee George J. Ferrante				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ovarian cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death one year				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Anthony Riley, MD			
	29c. License number D25205				29d. Date signed (Month, Day, Year) March 16, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GMC 6701 N-Charles St. Balt. Md 21204				31. Data filed (Month, Day, Year) MAR 22 2000			
	32. Registrar's Signature B. Sparks				33. State Registrar MAR 22 2000			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09320

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rosetta A. Sypula

2. Date of Death
Month Day Year
March 19, 20003. Time of Death
11:00 PM

4a. Facility Name (If not institution, give street and number)

504 MARION ROAD

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral
Director5. Social Security Number
175.10.61096. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
87 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
May 30, 19129. Birthplace (State or Foreign
Country)
PA

Usual Residence of Decedent

10a. State
MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

504 MARION ROAD

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: white15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
HAIRDRESSER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

John W. Schmuck

18. Mother's Name (First, Middle, Maiden Surname)

Annie R. Waughtel

19a. Informant's Name/Relationship (Type, Print)

Mary Jane R. Whaley - daug.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

504 Marion Rd., Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Susquahanna Mem. Gardens

Date

3/24/00

20c. Location - City or Town, State

York, PA

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, PA

426 Crain Hwy., SW, Glen Burnie, MD 21061

Physician
/Medical
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. END STAGE HEPATIC CIRRHOSIS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Elliott Garbety MD

29c. License number

D20094

29d. Date signed (Month, Day, Year)

03/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliott Garbety MD 7845 Oakwood Rd, Glen Burnie, MD, 21061

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09321
Certificate of Death Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Nicholas Scott</u>		2. Date of Death Month <u>March</u> Day <u>13</u> Year <u>2000</u>		3. Time of Death <u>7:20 PM</u>
	4a. Facility Name (If not institution, give street and number) <u>Harbor Hospital Center</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>none</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. _____	If Under 1 Year Months _____ Days _____	If Under 24 Hrs. Hours _____ Min. <u>3</u>
	8. Date of Birth (Month, Day, Year) <u>3 3 13 2000</u>		9. Birthplace (State or Foreign Country) <u>MD</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <u>3412 Spelman Road</u>			10f. Zip Code <u>21225</u>		10g. Citizen of What Country? <u>United States</u>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: _____		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: _____	
14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4or 5+) _____			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Infant</u>		16b. Kind of Business/Industry <u>Infant</u>
17. Father's Name (First, Middle, Last) <u>Melvin Douglas Scott</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Nichelle Monique Smith</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Nichelle Smith/mother</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3412 Spelman Rad Baltimore, MD 21225</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____			20b. Place of Disposition (Name of cemetery, crematory or other place) Date _____		20c. Location - City or Town, State
21. Signature of Funeral Service Licensee <u>Ronald S. Wade, Director</u>			22. Name and Address of Facility <u>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</u>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <u>Preterm delivery at 22 wks</u> Due to (or as a consequence of): _____</p> <p>b. _____ Due to (or as a consequence of): _____</p> <p>c. _____ Due to (or as a consequence of): _____</p> <p>d. _____</p> </div> <div style="width: 10%; text-align: center;"> <p>Approximate interval between Onset and Death</p> </div> </div>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) _____		28b. Time of Injury M _____	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>Dr. Kwon</u>		29c. License number <u>D0050955</u>		29d. Date signed (Month, Day, Year) <u>March 13/2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Soo Kwon 3001 S. Hanover Street</u>					
31. Date filed (Month, Day, Year) <u>MAR 22 2000</u>		32. Registrar's Signature <u>B. Sparks</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AAH

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09322

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Robert Sullivan

2. Date of Death

March 18 2000

Day Year

3. Time of Death

6:20pm.

4a. Facility Name (If not institution, give street and number)

Westminster Nursing Home

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

214-24-4601

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 16 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 Marys Court East

10f. Zip Code

21048

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1945-1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Food store

17. Father's Name (First, Middle, Last)

James Linwood Sullivan

18. Mother's Name (First, Middle, Maiden Surname)

Sally Mae Burnham

19a. Informant's Name/Relationship (Type, Print)

Hilda E. Sullivan - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Marys Court East Finksburg, MD 21048

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

Mar 22, 2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd. Owings Mills, MD 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D51705

29d. Date signed (Month, Day, Year)

3-21-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Pansariya, MD 419F Malcolm Dr, Westminster MD 21157

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09323

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERTHA SCHULTZ

2. Date of Death

MAR 19, 2000

3. Time of Death

0725

4a. Facility Name (If not institution, give street and number)

8506 VALLEY FIELD ROAD

4b. City, Town, or Location of Death

LUTHERVILLE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

218-18-6686

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 23, 1923

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

Md.

10b. County

BALTIMORE

10c. City, Town or Location

LUTHERVILLE, MD.

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8506 VALLEY FIELD ROAD

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurses Aid

16b. Kind of Business/Industry

Doctor's office

17. Father's Name (First, Middle, Last)

John Amoss

18. Mother's Name (First, Middle, Maiden Surname)

Laura O'Leary

19a. Informant's Name/Relationship (Type, Print)

Kenneth Amoss (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7755 Lawrence Ave. Pasadena MD, 21122

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Cemetery

Date

3/23/2000

20c. Location - City or Town, State

BALTO MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME, CHD.

7527 HARFORD RD. BALTO. MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HYPERCHOLESTEROLEMIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D50216

29d. Date signed (Month, Day, Year)

3/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Siala, MD 7801 York Rd Baltimore MD 21204

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09324

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY THREATT		2. Date of Death Month MARCH Day 20th Year 2000		3. Time of Death 17:15
	4a. Facility Name (If not institution, give street and number) RAVENWOOD NURSING HOME		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 219-28-3424	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) JAN 10 1911		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 2813 ULMAN AVENUE		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) College		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry PRIVATE		
	17. Father's Name (First, Middle, Last) ISACC SNOWDEN		18. Mother's Name (First, Middle, Maiden Surname) ELLA SNOWDEN		
	19. Informant's Name/Relationship (Type, Print) Thomas J. Ireland/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2813 Ulman Avenue, Baltimore, Maryland 21215		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NEW CATHEDRAL		20c. Location - City or Town, State 3-24-00 BALTIMORE, MARYLAND
	21. Signature of Funeral Director (Typed Name) William C Brown		22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE		
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE YEARS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Old tobacco use contributa to the causa of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS TYPE II					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Dr. Vasanthakumar		29c. License number D42510		29d. Date signed (Month, Day, Year) MARCH 20th 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. VASANTHA KUMAR, MD. 821 N. EUTAW ST. #407, MD 21201					
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature Benita S. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09325

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLIFTON CLAYTON TOLSON				2. Date of Death Month 3 Day 9 Year 2000		3. Time of Death 0603		
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number none		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 14		8. Date of Birth (Month, Day, Year) 2/26/00		
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MD		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1713 Gertrude Street		10f. Zip Code 21216		10g. Citizen of What Country? USA					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) none		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none		16b. Kind of Business/Industry none					
17. Father's Name (First, Middle, Last) unknown		18. Mother's Name (First, Middle, Maiden Surname) Shameleka Toulson							
19a. Informant's Name/Relationship (Type, Print) UMMS		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 S. Greene Street Baltimore, MD 21201							
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Data		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE RENAL FAILURE Due to (or as a consequence of): b. RESPIRATORY DISTRESS SYNDROME Due to (or as a consequence of): c. INTRAVENTRICULAR HEMORRHAGE Due to (or as a consequence of): d. EXTREME PREMATURITY		Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STATUS EPILEPTICUS		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Sandip Patel		29c. License number D55511		29d. Date signed (Month, Day, Year) 3/9/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY OF MARYLAND		31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature B. Sparks					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09326

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Don Francis Vernago				2. Date of Death Month Day Year March 15, 2000		3. Time of Death 7:50 AM		
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital Of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-52-8133		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 14, 1952		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1873 North Gay Street		10f. Zip Code 21213		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Auto Repair		17. Father's Name (First, Middle, Last) Walter Vernago		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Warns	
19a. Informant's Name/Relationship (Type, Print) Walter Vernago / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Mauser Dr. Bel Air, Maryland 21015		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 03/17/00		20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee Thomas Gregor		22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPOXIC BRAIN DAMAGE Due to (or as a consequence of): complicating cocaine intoxication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Styck March CERTIFICATION APPROVED BY MEDICAL EXAMINER		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) unknown		28b. Time of Injury unknown	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) unknown		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject ingested drugs		28f. Location (Street and Number or Rural Route Number, City or Town, State) unknown			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Manisha Bahl, M.D.		29c. License number P 13452		29d. Date signed (Month, Day, Year) MARCH 15 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANISHA BAHL GOOD SAMARITAN HOSPITAL		31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature [Signature]		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21239			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09327

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louis O. Wise, Jr.				2. Date of Death Month Day Year March 11, 2000				3. Time of Death 12:45 PM		
	4a. Facility Name (If not institution, give street and number) 15 Magruder Avenue				4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 217-32-7639		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 16, 1935		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 Yes 2 No
10e. Street and Number 15 Magruder Avenue				10f. Zip Code 21228				10g. Citizen of What Country? United States			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lithographer				16b. Kind of Business/Industry Lithography			
17. Father's Name (First, Middle, Last) Louis O. Wise, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Blanche Ewing					
19a. Informant's Name/Relationship (Type, Print) Reva M. Wise-Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Magruder Avenue, Catonsville, Maryland 21228					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery				20c. Location - City or Town, State 03-15-00 Baltimore, Maryland			
21. Signature of Funeral Service Licensee Lisa S. Johnson						22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ESOPHAGEAL CANCER										Approximate Interval Between Onset and Death 8 MONTHS	
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LIVER METASTASES										23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
24a. Was an autopsy performed? 1 Yes 2 No										24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28b. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Jane Portnow MD						29c. License number D0053856			29d. Date signed (Month, Day, Year) March 14, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANE PORTNOW JOHNS HOPKINS HOSP. 600 N. WOLFE ST. BALTIMORE, MD 21287											
31. Date filed (Month, Day, Year) MAR 22 2000				32. Registrar's Signature Jane B. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09328

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annie L. Whitfield				2. Date of Death Month Day Year Mar. 19, 2000				3. Time of Death 3:40pm	
	4a. Facility Name (If not institution, give street and number) Manor Care Nursing Home				4b. City, Town, or Location of Death Baltimore				4c. County of Death NA	
Funeral Director	5. Social Security Number 212-26-0158		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) 06-29-25		9. Birthplace (State or Foreign Country) SC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 3915 Fordleigh Road Apt. "D"				10f. Zip Code 21215		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic			16b. Kind of Business/Industry other people homes		
	17. Father's Name (First, Middle, Last) Dave Armstrong				18. Mother's Name (First, Middle, Maiden Surname) Annie M. Armstrong					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) William Whitfield				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3915 Fordleigh Road Apt. "D" Baltimore, MD 21215					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens 03-24-2000 Dundalk, MD				20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Renal Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6 months a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D45475		29d. Date signed (Month, Day, Year) 3/20/00			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Rahman 17 Fontana Lane #105 Baltimore MD 21237									
	31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature <i>[Signature]</i>							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09329

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BOYD WILSON				2. Date of Death Month Day Year March 10, 2000				3. Time of Death 2:10 P.M.		
	4e. Facility Name (If not institution, give street and number) 1400 East Madison Street, Apartment 808				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A		
Funeral Director	5. Social Security Number unknown		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Sept 29, 1924		9. Birthplace (State or Foreign Country) unknown		
	Usual Residence of Decedent										
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1400 E. Madison Street #808				10f. Zip Code 21205				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown				16b. Kind of Business/Industry unknown			
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown							
19e. Informant's Name/Relationship (Type, Print) O.C.M.E.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201							
20e. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier [Signature] 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) March 11, 2000									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature [Signature]									

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09330

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN P. WOLFF, SR.

2. Date of Death

March 19, 2000

3. Time of Death

12:33 p.m.

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

216-36-9831

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 4, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2506 Lincrest Road

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Heating & Air Cond. Co.

17. Father's Name (First, Middle, Last)

Leo Wolff

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Fertitta

19a. Informant's Name/Relationship (Type, Print)

John P. Wolff, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2821 Orchard Lake Drive, Baldwin, MD 21013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

3/23/00

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Bryan A. Wellen

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

b. BRAIN METASTASIS

Due to (or as a consequence of):

c. LIVER METASTASIS

Due to (or as a consequence of):

d. PNEUMONIA

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Syed E. Mahmood

29c. License number

D45921

29d. Date signed (Month, Day, Year)

MARCH 20, 2000
MARYLAND 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED E. MAHMOOD 4C NORTH AVENUE SUITE 424 BEL AIR

31. Date filed (Month, Day, Year)

MAR 22 2000

32. Registrar's Signature

Denise P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

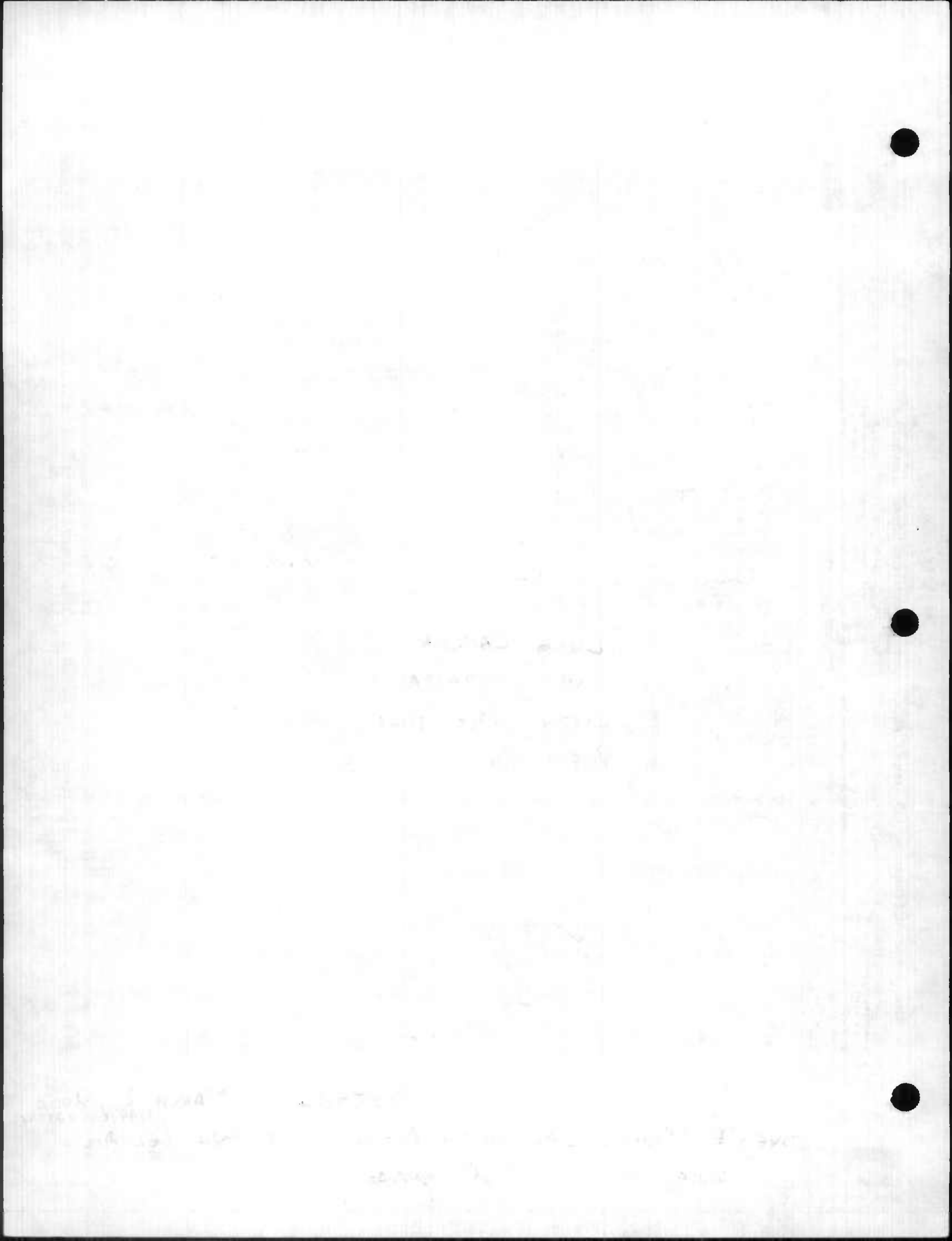
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09331

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE THOMAS WHITE JR.				2. Date of Death Month Day Year march 19 00		3. Time of Death 1400	
	4a. Facility Name (If not institution, give street and number) DEATON SPECIALTY HOSPITAL & HOME				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NIA	
Funeral Director	5. Social Security Number 212-94-1760		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 35 Yrs.		8. Date of Birth Month Day Year June 11, 1964	
	9. Birthplace (State or Foreign) Maryland		10a. State MD		10b. County NIA		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 152 S. Hilton St.		10f. Zip Code 21229		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) George T. White Sr.				18. Mother's Name (First, Middle, Maiden Surname) Loretta Wilson			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Loretta White - mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 152 S. Hilton St. Balto, MD. 21229			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Location - City or Town, State Baltimore, MD		20d. Date 3-25-00	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Gay P. Marsh Funeral Home P.A. 270 Fredrickson Pass Balto, MD. 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ADVANCED AIDS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV ENCEPHALOPATHY, HEPATITIS C & HEPATIC INSUFFICIENCY, WASTING, MAI, ENCEPHALOPATHY						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature] MD		29c. License number D52394		29d. Date signed (Month, Day, Year) 3-21-2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ila Mulasi MD, 29 S. Greene Street, suite #300, Baltimore MD, 21201							
	31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature [Signature]					

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Vertical handwritten text on the right margin, possibly a date or page number.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09332

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Margaret Wilson</i>		2. Date of Death Month <i>March</i> Day <i>21</i> Year <i>2000</i>		3. Time of Death <i>11:00 AM</i>
	4a. Facility Name (If not institution, give street and number) <i>7933 Elvaton Road</i>		4b. City, Town, or Location of Death <i>Glen Burnie</i>		4c. County of Death <i>Anne Arundel</i>
Funeral Director	5. Social Security Number <i>234.76.4825</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>52</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>8/9/47</i>		9. Birthplace (State or Foreign Country) <i>WVA</i>		
Usual Residence of Decedent					
10a. State <i>MD</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Glen Burnie</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <i>7933 Elvaton Road</i>		10f. Zip Code <i>21061</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>white</i>					
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Inspector</i>		16b. Kind of Business/Industry <i>David Edward Co., LTD</i>	
17. Father's Name (First, Middle, Last) <i>Jesse Montgomery</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Hilda Montgomery</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Harland Wilson, Jr. - Son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7933 Elvaton Road, Glen Burnie, MD 21061</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Glen Haven Mem. PK</i>		20c. Location - City or Town, State <i>3/24/00 Glen Burnie, MD</i>	
21. Signature of Funeral Service Licensee <i>Kelly Gregory Fink</i>		22. Name and Address of Facility <i>FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Paroventre Cancer</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>10 months</i>		Approximate Interval Between Onset and Death <i>10 months</i>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Peter P. Ramirez MD</i>		29c. License number <i>047137</i>		29d. Date signed (Month, Day, Year) <i>March, 21, 2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>PETER P. RAMIREZ MD 7845 Oakwood Rd Glen Burnie Md 21061</i>					
State Registrar	31. Date filed (Month, Day, Year) <i>MAR 22 2000</i>		32. Registrar's Signature <i>B. Sparks</i>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09333

Delete description Part II

Certificate of Death

HCHD BRH Reg. No. 03/07/00

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MABEL ESTES ANDREWS

2. Date of Death

MARCH 4, 2000 4:04 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-16-5390

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 18, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

407 Moore's Mill Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Public Education

17. Father's Name (First, Middle, Last)

David Madison Estes

18. Mother's Name (First, Middle, Maiden Surname)

Mollie (nmn) Day

19a. Informant's Name/Relationship (Type, Print)

Rachel Ferrara - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8717 Southern Breeze Dr., Orlando, FL 32836

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Grdns.

Date

3/8/00

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

50 West Broadway, Bel Air, Maryland 21014

23a. Part 1. Enter the disease, or combination of diseases, that contributed to the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

1 DAY

a. Due to (or as a consequence of):

CONGESTIVE HEART FAILURE

DAYS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

29b. Signature and title of certifier

29c. License number

D24034

29d. Date signed (Month, Day, Year)

3/4/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMOTHY LOW M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 7 - 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

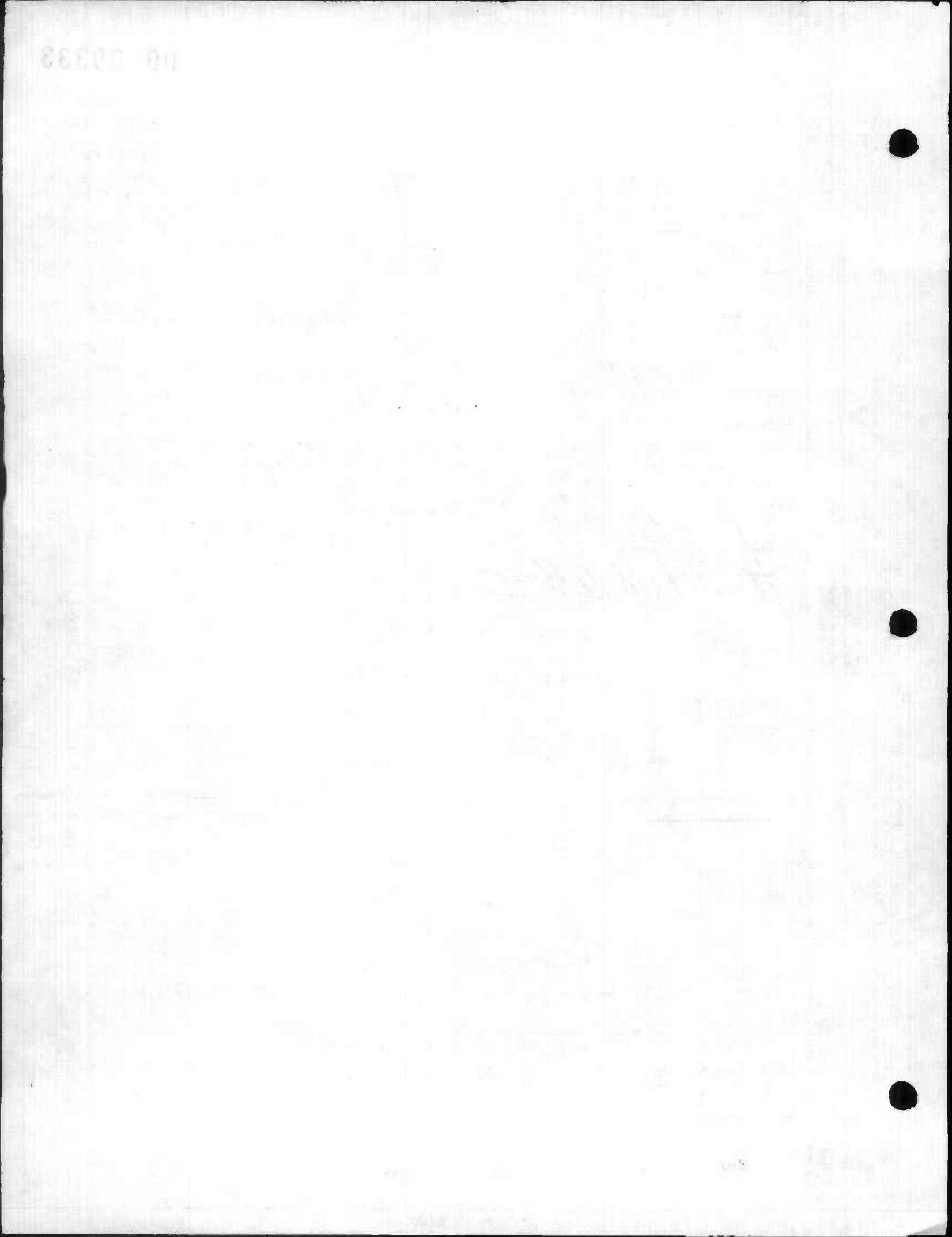
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09334

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HAZEL VIRGINIA ADKINS

2. Date of Death
Month Day Year
MARCH 1, 20003. Time of Death
12:05 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

216-22-9507

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 14, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7218 Mountindale Road

10f. Zip Code

21702

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Self

17. Father's Name (First, Middle, Last)

Amos Stine

18. Mother's Name (First, Middle, Maiden Summa)

Nellie Naydlor

19a. Informant's Name/Relationship (Type, Print)

Earl Adkins / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7218 Mountindale Rd, Frederick, MD 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem Gardens

Date

03/06/00

20c. Location - City or Town, State

Frederick, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Staufner Funeral Homes, P.A.

P.O. Box 1819, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Peritonitis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Spontaneous bowel perforation

Due to (or as a consequence of):

3 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recto vaginal fistula, Chronic renal failure, hypertension, hypothyroidism, depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35183

29d. Date signed (Month, Day, Year)

3/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ali J. Afari-Kich 300 W 9th St Frederick MD

31. Date filed (Month, Day, Year)

MAR 03 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1880



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09335

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SISTER ODILE ALLNUTT				2. Date of Death Month Day Year MARCH 3, 2000				3. Time of Death 6:50 AM	
	4a. Facility Name (If not institution, give street and number) VILLA ST. MICHAEL				4b. City, Town, or Location of Death EMMITSBURG				4c. County of Death FREDERICK	
Funeral Director	5. Social Security Number 061-42-0111		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) MAR. 5, 1908		9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County FREDERICK		10c. City, Town or Location EMMITSBURG	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 333 S. SETON AVE.		10f. Zip Code 21727		10g. Citizen of What Country? U. S. A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE		16b. Kind of Business/Industry DAUGHTER OF CHARITY		17. Father's Name (First, Middle, Last) GEORGE ALLNUTT		18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH D. JONES		19a. Informant's Name/Relationship (Type, Print) SISTER CAMILLA HARANT/SUPERIOR		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 S. SETON AVE., EMMITSBURG, MD. 21727		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOSEPH'S		20c. Location - City or Town, State EMMITSBURG, MD. 21727		21. Signature of Funeral Service Licensee John M. Skiles		
22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Heart Failure Due to (or as a consequence of): Severe Parkinson's Disease Due to (or as a consequence of): with Dementia Due to (or as a consequence of):		Approximate Interval Between Onset and Death 2 months 10 yrs.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. G tube dependent		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Alan Carroll M.D.		29c. License number D18705		29d. Date signed (Month, Day, Year) MARCH 3, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN CARROLL M.D. 310 S. SETON AVE. EMMITSBURG, MD. 21727		31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09336

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carl Edward Brown				2. Date of Death Month Day Year Mar 2 2000		3. Time of Death 5:45 pm	
	4a. Facility Name (If not institution, give street and number) 550 E. Nicodemus Road				4b. City, Town, or Location of Death Westminister		4c. County of Death Carroll County	
Funeral Director	5. Social Security Number 220-10-5290	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 18, 1906		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Carroll County		10c. City, Town or Location Westminister			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 550 E. Nicodemus Road				10f. Zip Code 21157		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Superintendent			16b. Kind of Business/Industry US Postal Service	
17. Father's Name (First, Middle, Last) Jesse W. Brown				18. Mother's Name (First, Middle, Maiden Surname) Frances Ann Hobbs				
19a. Informant's Name/Relationship (Type, Print) Romaine L. Eyler, daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 550 E. Nicodemus Road, Westminister, MD 21157				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State 3/6/2000 Frederick, Maryland		
21. Signature of Funeral Service Licensee Richard E. Gray mo 0255				22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic prostate cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 11 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Thomas K. Galvin III mo			29c. License number D3166c		29d. Date signed (Month, Day, Year) 3/3/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas K. Galvin III mo 295 Stoner Ave Westminister MD 21157								
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1938

1938

1938

1938

1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09337

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Benneche		2. Date of Death Month Day Year Mar. 3, 2000		3. Time of Death 8:10 PM
	4a. Facility Name (If not institution, give street and number) Frederick Healthcare Center		4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
Funeral Director	5. Social Security Number 301-42-1855	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Day Year May 27, 1905		9. Birthplace (State or Foreign Country) England		
Usual Residence of Decedent					
10a. State MD.		10b. County Frederick		10c. City, Town or Location Frederick	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 205 Thomas Ave.			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home	
17. Father's Name (First, Middle, Last) James Frederick Marshall			18. Mother's Name (First, Middle, Maiden Surname) Mary Alice Barclay		
19a. Informant's Name/Relationship (Type, Print) Nancy McAllister (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1795 Hillmeade Sqare, Frederick, MD. 21702			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lutheran Cemetery		20c. Location - City or Town, State 3/6 Middletown, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Atrial Fibrillation Due to (or as a consequence of): Approximate Interval Between Onset and Death 3-5 years					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Atrial Fibrillation					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D21944		29d. Date signed (Month, Day, Year) 3/8/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jane S. Grisson 300 W 9th St. Frederick, md 21701					
31. Date filed (Month, Day, Year) MAR 13 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09338

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emmett Watson Beachley

2. Date of Death

March 6, 2000

3. Time of Death

5:30 pm

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

220-28-9089

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug. 20, 1933

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Frederick

10c. City, Town or Location

Jefferson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6126 Elaine Dr.

10f. Zip Code

21755

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1952-1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

protective officer

16b. Kind of Business/Industry

federal government

17. Father's Name (First, Middle, Last)

Charles Dewey Beachley

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Frances Nash

19a. Informant's Name/Relationship (Type, Print)

Patricia H. Beachley (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6126 Elaine Dr., Jefferson, MD. 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lutheran Cemetery

Date

3/9

20c. Location - City or Town, State

Jefferson, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home
31 E. Main St., Middletown, MD. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Pneumonia

b.

Due to (or as a consequence of):

Atelectasis

c.

Due to (or as a consequence of):

Chronic Obstructive Pulmonary Disease

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Weeks

Days

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Cardiomyopathy
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D47556

29d. Date signed (Month, Day, Year)

3/7/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William A. Johnson, MD, 172 THOMAS JOHNSON DRIVE, FREDERICK 21702

State
Registrar

31. Date filed (Month, Day, Year)

MAR 13 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09339

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GARRY WAYNE BOWINS

2. Date of Death

Month Day Year
March 10 2000

3. Time of Death

12:03 P.M.

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral
Director

5. Social Security Number

213-60-7992

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 19, 1953

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

FREDERICK

10c. City, Town or Location

FREDERICK

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

98 MARYLAND AVE

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MEDICAL TECHICIAN

16b. Kind of Business/Industry

MEDICAL

17. Father's Name (First, Middle, Last)

JAMES BOWINS

18. Mother's Name (First, Middle, Maiden Surname)

MAXINE FREELAND

19a. Informant's Name/Relationship (Type, Print)

JAMES BOWINS (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

98 MARYLAND AVE. FREDERICK MD. 21701

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RESTHAVEN MEM. GAR.

Date

17 MAR

20c. Location - City or Town, State

2000 MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

GARY L. ROLLINS FUNERAL HOME 21701
110 WEST SOUTH ST FREDREICK MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. massive GI Bleeding

Due to (or as a consequence of):

3 days

c. diffuse intracranial vascular congestion

Due to (or as a consequence of):

3 days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AIDS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D14626

29d. Date signed (Month, Day, Year)

March 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GG Russell 501 W 3rd St Frederick MD

State
Registrar

31. Date filed (Month, Day, Year)

MAR 17 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09340

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Burle D. Burkhammer				2. Date of Death Month March Day 11 Year 2000				3. Time of Death 8:48 P.M.			
	4a. Facility Name (If not institution, give street and number) 6563 Cornell Road				4b. City, Town, or Location of Death Bryans Road				4c. County of Death Charles			
Funeral Director	5. Social Security Number 233-52-4527		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) August 23, 1932		9. Birthplace (State or Foreign Country) West Virginia			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Charles		10c. City, Town or Location Bryans Road				10d. Inside City Limits 1 Yes 2 No			
	10e. Street and Number 6563 Cornell Road				10f. Zip Code 20616				10g. Citizen of What Country? United States			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Korean Conflict		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4or 5+) Unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter				16b. Kind of Business/Industry Painting			
	17. Father's Name (First, Middle, Last) John Burkhammer				18. Mother's Name (First, Middle, Maiden Surname) Jan Unknown							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Christ G. Burkhammer/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6563 Cornell Road, Bryans Road, MD 20616							
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Geo. Washington University Medical Center				Date March 11 2000		20c. Location - City or Town, State Washington, D.C.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Columbia Mortuary Services, Inc P.O. Box 58007 Washington, D.C. 20037							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC ADENOCARCINOMA of Lung x metast Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):											
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
State Registrar	25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how Injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number 020629		29d. Date signed (Month, Day, Year) 3/14/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George H. Warrick, MD, Warrick, Md. 20603											
31. Date filed (Month, Day, Year) MAR 13 2000		32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

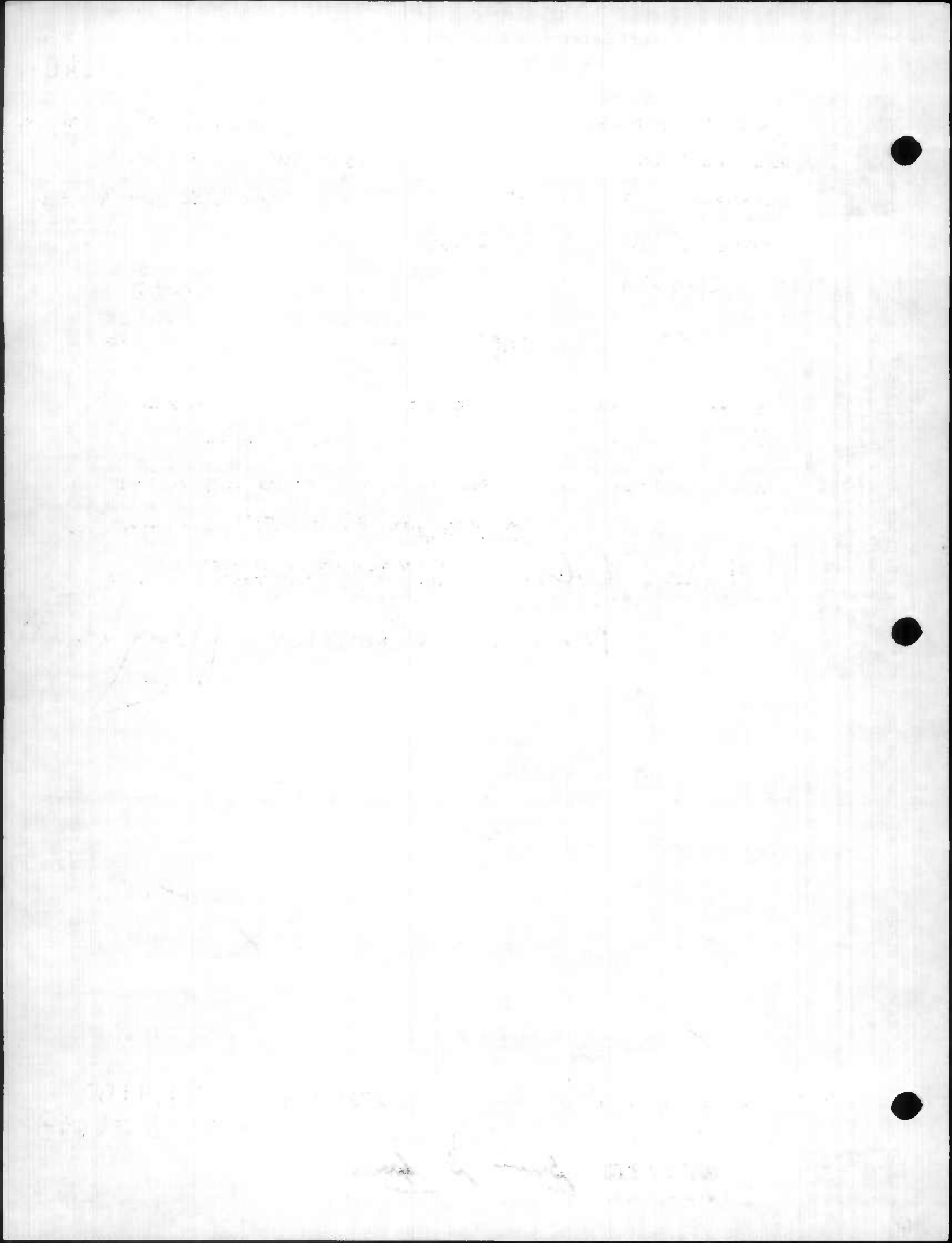
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 09341**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Virginia Cordell

2. Date of Death

March 11, 2000 Year

3. Time of Death

9:15 PM

4a. Facility Name (If not institution, give street and number)

Frederick Health Care Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

220-28-8614

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 9, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1414 West 12th Street

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Lab Technician

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Douglas Samuel Castle

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Elsie Lambert

19a. Informant's Name/Relationship (Type, Print)

Mrs. Shirley Ann Krantz, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4486 Willow Tree Court, Middletown, Md. 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery, March 15, 2000

Data

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Richard E. Sharp M00255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home
106 East Church St., Frederick, Maryland 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Hypernatremia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

week

b.

Dehydration

Due to (or as a consequence of):

week

c.

Dementic

Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William H. Johnson M.D.

29c. License number

D47556

29d. Date signed (Month, Day, Year)

March 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM H. JOHNSON, M.D., 172 THOMAS J. JOHNSON DRIVE, FREDERICK, MD 21702

31. Date filed (Month, Day, Year)

MAR 13 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09342

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Bernard Chomel				2. Date of Death Month Day Year March 6, 2000		3. Time of Death 11:34 pm	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 308-01-4139		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Jun 5, 1918	
	9. Birthplace (State or Foreign Country) Indiana		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
Usual Residence of Decedent								
10a. State Maryland			10b. County Frederick			10c. City, Town or Location Frederick		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number 7512 Oakmont Drive			10f. Zip Code 21702		
10g. Citizen of What Country? U.S.A.			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 4		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer			16b. Kind of Business/Industry Manufacturing			17. Father's Name (First, Middle, Last) Bernard Chomel		
18. Mother's Name (First, Middle, Maiden Surname) Bonaventure			19a. Informant's Name/Relationship (Type, Print) Michael J. Chomel/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8017 Devilbiss Bridge Road, Frederick, MD 21701		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Cemetery Mar 10, 2000			20c. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee <i>Keith Lynn Roberson</i> M00706			22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) a. <u>Upper Gastrointestinal Hemorrhage</u> Due to (or as a consequence of):								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Syncope; Coronary Artery Disease; Gastroesophageal Reflux Fractured right hip and shoulder								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) Mar 05, 2000		28b. Time of Injury 11:23a M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred Victim fell while walking			28e. Location (Street and Number or Rural Route Number, City or Town, State) 7512 Oakmont Dr Frederick, Maryland 21702					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Andrew J. Zarick, Jr.</i>			29c. License number D35164			29d. Date signed (Month, Day, Year) March 09, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew J. Zarick, Jr., MD, 1080 West Patrick Street, Frederick, Maryland 21703								
31. Date filed (Month, Day, Year) MAR 09 2000			32. Registrar's Signature <i>P. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09343

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elmer Hunter Dillsworth				2. Date of Death Month Day Year Mar. 9, 2000				3. Time of Death 1:50 AM																					
	4a. Facility Name (If not institution, give street and number) Cuppitt-Weeks Nursing Home				4b. City, Town, or Location of Death Oakland				4c. County of Death Garrett																					
Funeral Director	5. Social Security Number 212-18-1973		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 27, 1916		9. Birthplace (State or Foreign Country) Maryland																					
	Usual Residence of Decedent																													
10a. State MD		10b. County Garrett		10c. City, Town or Location Oakland				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
10e. Street and Number 206 Sunnyside Road				10f. Zip Code 21550				10g. Citizen of What Country? USA																						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White																						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer				16b. Kind of Business/Industry Lumber Company																						
17. Father's Name (First, Middle, Last) Mark ----- Dillsworth				18. Mother's Name (First, Middle, Maiden Surname) Rebecca ----- Warren																										
19a. Informant's Name/Relationship (Type, Print) Howard F. Dillsworth/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Sunnyside Road, Oakland, Md. 21550																										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Underwood Cemetery		20c. Date 3/12/00		20d. Location - City or Town, State Oakland, Md.																								
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550																										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																														
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>subdural hematoma</td> <td>4 months</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>respiratory failure</td> <td>4 months</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3">Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	subdural hematoma	4 months	Due to (or as a consequence of):			b.	respiratory failure	4 months	Due to (or as a consequence of):			c.	Due to (or as a consequence of):			d.	Due to (or as a consequence of):		
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	subdural hematoma	4 months																											
	Due to (or as a consequence of):																													
	b.	respiratory failure	4 months																											
	Due to (or as a consequence of):																													
c.	Due to (or as a consequence of):																													
d.	Due to (or as a consequence of):																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																						
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																														
29b. Signature and title of certifier 				29c. License number D15333		29d. Date signed (Month, Day, Year) 3/10/00																								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, M.D. 311 N. Fourth St., Oakland, Md. 21550																														
31. Date filed (Month, Day, Year) MAR 10 2000				32. Registrar's Signature 																										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09344

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Joseph Delbert Durst		2. Date of Death Month FEB Day 27 Year 2000		3. Time of Death 5:20 PM
4a. Facility Name (If not institution, give street and number) Goodwill Mennonite Home		4b. City, Town, or Location of Death Grantsville		4c. County of Death Garrett
5. Social Security Number 213-40-3465	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58	8. Date of Birth (Month, Day, Year) Feb 21, 1942	
9. Birthplace (State or Foreign Country) Maryland		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State MD		10b. County Garrett		10c. City, Town or Location Grantsville
10d. Street and Number 21 N. Pennsylvania Avenue		10f. Zip Code 21536		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+) Collega		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equip. Tire Manager		16b. Kind of Business/Industry Tire Manufacture		
17. Father's Name (First, Middle, Last) Elmer Clark Durst		18. Mother's Name (First, Middle, Maiden Sumama) Gladys L. (Durst)		
19a. Informant's Name/Relationship (Type, Print) Mildred P. Pope/sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1347 Springs Rd., Springs, PA 15562		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grantsville Cem. Feb. 29, 2000		20c. Location - City or Town, State Grantsville, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. STROKE				Approximate Interval Between Onset and Death 2 months
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28b. Describe how injury occurred		
28c. Location (Street and Number or Rural Route Number, City or Town, State)		28d. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D 34079
29d. Data signed (Month, Day, Year) FEB 28, 2000		30. Name and address of person who completed certificate of death (Item 22) (Type, Print) JAMES E. BEITEL MD Grantsville MD 21536		
31. Date filed (Month, Day, Year) MAR - 1 2000		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09345

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Samantha Marie Dougherty				2. Date of Death Month March Day 9 Year 2000		3. Time of Death 2:15 p.m.	
4a. Facility Name (If not institution, give street and number) 26404 Forest Hall Drive				4b. City, Town, or Location of Death Helen		4c. County of Death St. Mary's	
5. Social Security Number 216-53-7167		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 13, 1998	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent							
10a. State MD		10b. County St. Mary's		10c. City, Town or Location Helen		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 26404 Forest Hall Drive				10f. Zip Code 20635		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Infant		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) James Edward Dougherty				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Ann Weiss			
19a. Informant's Name/Relationship (Type, Print) James Dougherty/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26404 Forest Hall Dr. Helen, MD. 20635			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gar.		Date 3/13/00		20c. Location - City or Town, State Waldorf, MD.	
21. Signature of Funeral Service Licensee David C. Schulz		M00945		22. Name and Address of Facility BRINSFIELD-ECHOLS FUNERAL HOME, P.A. P.O. BOX 128 CHARLOTTE HALL, MD. 20622			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. MITOCHONDRIAL DISEASE RESPIRATORY CHAIN Due to (or as a consequence of): ENCEPHALOPATHY N.O.S.</p> <p>b. ENCEPHALOPATHY Due to (or as a consequence of):</p> <p>c. COMPLETE CONGENITAL HEART DISEASE, TRICUSPID DISEASE Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>LIFELONG</p> <p>2 MONTHS</p> <p>LIFELONG</p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FAILURE TO THRIVE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Keith J. Lindemann		29c. License number D0050458		29d. Date signed (Month, Day, Year) 3-10-2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keith J. Lindemann, M.D., 22576 MacArthur Blvd., Suite 354, California, MD 20619							
31. Date filed (Month, Day, Year) MAR 13 2000		32. Registrar's Signature B. Sparks					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09346

Amend Item 20bc3/6/00 HCHD Certificate of Death

BRH

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Marguerite Mae Decker				2. Date of Death Month March Day 3 Year 2000				3. Time of Death 1415	
4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Havre de Grace				4c. County of Death Harford	
5. Social Security Number 219-20-9432		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 2, 1925		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent									
10a. State MD		10b. County Harford		10c. City, Town or Location Havre de Grace				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 218 N. Paradise Rd.				10f. Zip Code 21078		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry In home		
17. Father's Name (First, Middle, Last) John Dudeck				18. Mother's Name (First, Middle, Maiden Surname) Sadie UNK					
19a. Informant's Name/Relationship (Type, Print) Virgil R. Decker, Jr. (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 N. Paradise Rd., Havre de Grace, MD 21078					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gardens		Date 3/6/00		20c. Location - City or Town, State Bel Air, Md.			
21. Signature of Funeral Service Licensee <i>James B. ...</i>				22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Chronic obstructive lung disease Due to (or as a consequence of): b. Respiratory Failure Due to (or as a consequence of): c. Arteriosclerotic Cardiovascular disease Due to (or as a consequence of): d. Diabetes Mellitus				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>J. Lee M.D.</i>				29c. License number D20661		29d. Date signed (Month, Day, Year) 3/3/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. T. Lee M.D. 665 Revolution St. Havre de Grace MD 21078									
31. Date filed (Month, Day, Year) MAR 6 - 2000		32. Registrar's Signature <i>B. Sparks</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09347

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Royal Dean

2. Date of Death

March 8, 2000

3. Time of Death

10:25 am

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

218-24-0698

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 24, 1929

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2610 Warren Way

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1947-67

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Security Officer

16b. Kind of Business/Industry

U. S. Military

17. Father's Name (First, Middle, Last)

Harold D.T. Dean

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Van Houten

19a. Informant's Name/Relationship (Type, Print)

Esther W. Dean/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2610 Warren Way, Frederick, Maryland 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematorium 3/10

Data

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Olin L. Molesworth P. A. Funeral Home
26401 Ridge Road, Damascus, Maryland 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulseless electrical activity

Due to (or as a consequence of):

b. Probable massive pulm. embolus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAD

Recent GI bleed

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D0055518

29d. Date signed (Month, Day, Year)

3/8/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chen Tung, M.D. 311 West 7th Street, Frederick, Maryland

State
Registrar

31. Date filed (Month, Day, Year)

MAR 10 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text, possibly a title or header, located in the upper middle section of the page.

X
X

Handwritten text, possibly a date or reference, located in the middle right section of the page.

X X

Handwritten text, possibly a signature or name, located in the bottom left section of the page.

Handwritten text, possibly a signature or name, located in the bottom middle section of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09348

Amended item#26per doctor 3/13/2000 Certificate of Death FCHD,KS Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AGNES FREELAND		2. Date of Death Month Day Year MARCH 7, 2000		3. Time of Death 6:19 AM
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL		4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK
Funeral Director	5. Social Security Number 219-36-3159	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) FEB. 3, 1938		9. Birthplace (State or Foreign Country) MD.		
Usual Residence of Decedent					
10a. State MD.		10b. County FREDERICK		10c. City, Town or Location FREDERICK	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 238 PHEBUS AVE.		10f. Zip Code 21701	
10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 TH College (1-4or 5+) College	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPER		16b. Kind of Business/Industry ST. JOHNS RC PRIEST HOUSE			
17. Father's Name (First, Middle, Last) WILLIAM JONES			18. Mother's Name (First, Middle, Maiden Surname) MARQUERITE SAPPINGTON		
19a. Informant's Name/Relationship (Type, Print) RENITA T. FREELAND (daug)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORTH POTOMAC, MD. 20878		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOHNS CEM.		20c. Location - City or Town, State MAR. 13, 2000 Fred MD
21. Signature of Funeral Service Licensee <i>Gary L. Rollins</i>			22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST FREDERICK MD 21701		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <i>Squamous cell carcinoma oral cavity</i> <i>Pulmonary embolism</i>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number D 0018063		29d. Date signed (Month, Day, Year) 3/1/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL MAJED MD 801 TOLL HOUSE AVE FREDERICK MD 21701					
31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature <i>[Signature]</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09349

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IONA RUTH FISHER				2. Date of Death Month Day Year February 29, 2000		3. Time of Death 12:02 am	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-10-3124		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) September 29, 1916	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) Maryland					
To Be Completed by Funeral Director	10a. State MD		10b. County Frederick		10c. City, Town or Location Thurmont		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 8313 Blacks Mill Road				10f. Zip Code 21788		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy Farmer		16b. Kind of Business/Industry Dairy Farm			
	17. Father's Name (First, Middle, Last) James Marion Havner				18. Mother's Name (First, Middle, Maiden Surname) Bessie Ruth Long			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Margaret Hoffman / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8313 Blacks Mill Rd, Thurmont, MD 21788			
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Blue Ridge Cemetery		Date 03/05/00		20c. Location - City or Town, State Thurmont, MD	
	21. Signature of Funeral Service Licensee <i>Staufier</i>				22. Name and Address of Facility Staufier Funeral Homes, P.A. P.O. Box 1819, Frederick, MD 21702			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>intracerebral bleed</i> Due to (or as a consequence of): b. <i>myocardial infarction</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 24 hrs 48 hrs							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Bronchitis</i> <i>Rheumatoid arthritis</i>							
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Staufier</i>		29c. License number 1022101		29d. Date signed (Month, Day, Year) 3/3/00	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Lloyd H. Spinks 1475 Long Ave Frederick MD 21702</i>							
31. Date filed (Month, Day, Year) MAR 03 2000		32. Registrar's Signature <i>Spinks</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09350

Amended item #12 3/16/00 FCHD, KS

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Madeline Virginia Grams

2. Date of Death

Mar. 10, 2000 Year

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

230 Mountain Terrace

4b. City, Town, or Location of Death

Myersville

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

215-78-3266

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 6, 1916

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Frederick

10c. City, Town or Location

Myersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

230 Mountain Terrace

10f. Zip Code

21773

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates: W. W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

John Springer

18. Mother's Name (First, Middle, Maiden Surname)

Cora Baker

19a. Informant's Name/Relationship (Type, Print)

Dorothy E. Gross (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2903 Station Rd., Middletown, MD. 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Locust Valley Bible Church 3/14 Middletown, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home
31 E. Main St., Middletown, MD. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. prob hyper-calcemia

Due to (or as a consequence of):

2d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Bone metastases

Due to (or as a consequence of):

1y

c. Breast Cancer

Due to (or as a consequence of):

2y

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 1462C

29d. Date signed (Month, Day, Year)

14 Mar - 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory P. Rausch, MD 501 West 7th street Frederick, MD 21702

31. Date filed (Month, Day, Year)

MAR 16 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

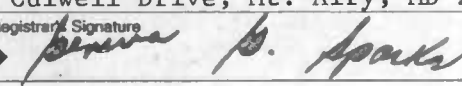
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09351

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Abraham Lincoln Gosnell				2. Date of Death Month Day Year March 3, 2000		3. Time of Death 10:15 a.m.		
	4a. Facility Name (If not institution, give street and number) Pleasant View Nursing Home				4b. City, Town, or Location of Death Mt. Airy		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 214-16-0031-A		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) March 1, 1908		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Mt. Airy		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5210 Sidney Road		10f. Zip Code 21771		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 16) College (14 or 16)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner/operator		16b. Kind of Business/Industry Gosnell's convenience store					
17. Father's Name (First, Middle, Last) Charles Smith Gosnell				18. Mother's Name (First, Middle, Maiden Surname) Augusta Elgin					
19a. Informant's Name/Relationship (Type, Print) Joan Gosnell / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5210 Sidney Rd., Mt. Airy, MD 21771					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery		20c. Location - City or Town, State 3/8/00 Mt. Airy, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Homes 8 East Ridgeville Blvd, Mt. Airy, MD 21771					
23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DYSPHAGIA Due to (or as a consequence of): CEREBRAL VASCULAR ACCIDENTS		Approximate Interval Between Onset and Death HOURS DAYS MONTHS-YEARS YEARS							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of Certifier  MD		29c. License number 026499		29d. Date signed (Month, Day, Year) 3-3-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ronald E. Miller, 4 Culwell Drive, Mt. Airy, MD 21771									
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09352

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH (nmn) GRUODIS

2. Date of Death

Month Day Year
MARCH 3, 2000

3. Time of Death

9:45 A.M.

4a. Facility Name (If not institution, give street and number)

625 Calliope Way

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

044-26-7475

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 3, 1903

9. Birthplace (State or Foreign Country)

Lithuania

Usual Residence of Decedent

10a. State
Maryland

10b. County

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

625 Calliope Way

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Supervisor of Maintenance

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Victoria Gruodis / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

625 Calliope Way, Mt. Airy, MD 21771

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Peter's Cath. Cem.

Date

3/6/00

20c. Location - City or Town, State

Libertytown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

8 E. Ridgeville Blvd., Mt. Airy, MD 21771

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bladder Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Carcinoma, Coronary Artery Disease

Factor 8 Deficiency, Sick Sinus Syndrome,

Hypertension, Deaf

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

041794

29d. Date signed (Month, Day, Year)

March 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Priscilla Callahan-Lyon, MD

911 Russell Ave Gaithersburg, MD 20879

State
Registrar

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09353

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLORIA ANN EDELEN HOLT				2. Date of Death Month Day Year March 10 2000				3. Time of Death 5:30am						
	4a. Facility Name (If not institution, give street and number) 3047 October Place				4b. City, Town, or Location of Death Waldorf				4c. County of Death Charles						
Funeral Director	5. Social Security Number 220-50-9773		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 3, 1951		9. Birthplace (State or Foreign Country) MARYLAND						
	Usual Residence of Decedent														
10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location WALDORF				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
10e. Street and Number 3047 F. OCTOBER PLACE				10f. Zip Code 20602		10g. Citizen of What Country? UNITED STATES									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 GRADE College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry PRIVATE							
17. Father's Name (First, Middle, Last) WILLIAM T. EDELEN				18. Mother's Name (First, Middle, Maiden Surname) MARTHA OPHELIA BAKER EDELEN											
19a. Informant's Name/Relationship (Type, Print) ANN MICHELLE HOLT / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3047 F. OCTOBER PLACE, WALDORF, MARYLAND 20602											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) HUNTT CREMATORY		Date 3/15/00		20c. Location - City or Town, State WALDORF, MARYLAND							
21. Signature of Funeral Service Licensee LYDIA C. THORNTON JOHNSON M00583				22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER OF CERVIX Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES - 2 HYPERTENSION RENAL FAILURE										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier V. Anmangandla		29c. License number D26064		29d. Date signed (Month, Day, Year) 3-10-2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vidyasagar Anmangandla, MD Charlotte Hall, Maryland 20622															
31. Date filed (Month, Day, Year) MAR 13 2000				32. Registrar's Signature B. Sparks											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09354

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM AUGUSTINE HILTON				2. Date of Death Month March Day 10 Year 2000		3. Time of Death 20:15	
	4a. Facility Name (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				4b. City, Town, or Location of Death PRINCE FREDERICK		4c. County of Death CALVERT	
Funeral Director	5. Social Security Number 220-16-4584		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 1, 1926	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location NEWBURG			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 12942 WEST HATTON ROAD				10f. Zip Code 20664		10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONSTRUCTION LABORER			16b. Kind of Business/Industry CONSTRUCTION	
17. Father's Name (First, Middle, Last) JAMES ALFRED HILTON				18. Mother's Name (First, Middle, Maiden Surname) MARY AGNES BROWN HILTON				
19a. Informant's Name/Relationship (Type, Print) JOANNE H. STALLWORTH / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6231 SPRING HILL DRIVE, GREENBELT, MARYLAND 20770				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY GHOST CHURCH CEM.		Date 3/14/00		20c. Location - City or Town, State ISSUE, MARYLAND
21. Signature of Funeral Service Licensee <i>Lydia C. Thornton Johnson</i> LYDIA C. THORNTON JOHNSON M00583				22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Advanced Alzheimer's Disease Due to (or as a consequence of): c. Parkinson's Disease Due to (or as a consequence of): d.								
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Paul Sparr</i>				29c. License number D45092		29d. Date signed (Month, Day, Year) 3/11/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Parul Jani, M.D. Dunkirk, MD 20754								
State Registrar	31. Date filed (Month, Day, Year) MAR 13 2000		32. Registrar's Signature <i>Benita B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09355

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILSON (NMN) HARVEY

2. Date of Death

Month Day Year
MARCH 10, 2000

3. Time of Death

12:10 AM

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral
Director

5. Social Security Number

306-22-6001

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MARCH 29, 1927

9. Birthplace (State or Foreign Country)

MICHIGAN

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

FREDERICK

10c. City, Town or Location

THURMONT

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

18 SANDY SPRING LANE

10f. Zip Code

21788

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COMMUNICATION SPECIALIST

16b. Kind of Business/Industry

DEPT. OF ARMY

17. Father's Name (First, Middle, Last)

JOHN

HARVEY

18. Mother's Name (First, Middle, Maiden Surname)

ALICE

HUMPHRY

19a. Informant's Name/Relationship (Type, Print)

DORIS MERCER (PERSONAL REP)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14724 SABILLASVILLE RD., THURMONT, MD 21788

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RESTHAVEN MEMORIAL GRDNS 3/13/00

Date

20c. Location - City or Town, State

FREDERICK, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
615 EAST MAIN ST., THURMONT, MD 21788

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Fibrosis

Coronary Artery Disease

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Tolino MD

29c. License number

MD 51610

29d. Date signed (Month, Day, Year)

3-10-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Tolino MD 1475 Tawney Ave Suite 204 Fred MD 21702

State
Registrar

31. Date filed (Month, Day, Year)

MAR 13 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09356

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY LLOYD HOKE				2. Date of Death Month Day Year MARCH 6, 2000		3. Time of Death 6:45 PM																											
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK																											
Funeral Director	5. Social Security Number 274-01-2306		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 26, 1910																											
	9. Birthplace (State or Foreign Country) ILLINOIS		10a. State MARYLAND		10b. County FREDERICK		10c. City, Town or Location THURMONT																											
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 30 SUMMIT AVE.		10f. Zip Code 21788		10g. Citizen of What Country? USA																											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRESIDENT		16b. Kind of Business/Industry FURNITURE COMPANY																													
	17. Father's Name (First, Middle, Last) HENRY GEORGE HOKE				18. Mother's Name (First, Middle, Maiden Surname) LULA K. GALL																													
	19a. Informant's Name/Relationship (Type, Print) CLARA MAY HOKE (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 SUMMIT AVE., THURMONT, MD 21788																													
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN HILL CEMETERY		20c. Location - City or Town, State WAYNESBORO, PA		20d. Date 3/10/00																											
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 E. MAIN ST., THURMONT, MD 21788																													
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Vent. fibrillation</td> <td rowspan="4">Approximate Interval Between Onset and Death 1h</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): ASCVD</td> <td rowspan="3">10 1/2</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	Vent. fibrillation	Approximate Interval Between Onset and Death 1h	b.	Due to (or as a consequence of): ASCVD	10 1/2	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):															
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<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
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		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																		
29b. Signature and title of certifier 				29c. License number D17549		29d. Date signed (Month, Day, Year) MARCH 8, 2000																												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM F. HARPER, MD 100 CENTER ST., THURMONT, MD 21788																																		
31. Date filed (Month, Day, Year) MAR 10 2000		32. Registrar's Signature 																																

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

00-1244-510

Dale Hahn

JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #27, 28A-P PER MEO G786 8-3-00 WR

State of Maryland Department of Health and Mental Hygiene

00 09357

AMEND ITEMS: #23 PART I, II, 27 PER MEO G782 4-19-00 MR.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dale Edward Hahn

2. Date of Death

March 04, 2000

3. Time of Death

06:18 A.M.

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

215-64-1956

6. Sex

1X M 2□ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 17 1954

9. Birthplace (State or Foreign Country)

Brunswick, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1X Yes 2□ No

10e. Street and Number

103 W. Orndorff Drive

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2□ Married

3□ Widowed 4X Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1□ Yes 2X No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Rotorex Air Conditioning

Walkersville, MD

17. Father's Name (First, Middle, Last)

John Hamilton Hahn

18. Mother's Name (First, Middle, Maiden Surname)

Blanche V. Frye Hahn

19a. Informant's Name/Relationship (Type, Print)

Blanche V. Hahn, Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 W. Orndorff Drive, Brunswick, MD 21716

20a. Method of Disposition

1X Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

3/7/2000

20c. Location - City or Town, State

Lovettsville, VA

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home
100 Petersville Rd., Brunswick, MD 21716

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

BRAIN HERNIATION

Due to (or as a consequence of):

ORGANIZING (SUBACUTE) SUBDURAL HEMATOMA

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RECURRENT PNEUMONIA AND SINUSITIS

ORGANIC BRAIN SYNDROME WITH PERSISTENT TREMORS

CHRONIC HEPATITIS PARANOID SCHIZOPHRENIA CIRRHOSIS

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4X Unknown

24a. Was an autopsy performed?

1X Yes 2□ No

24b. Were autopsy findings available prior to completion of cause of death?

1X Yes 2□ No

25. Was case referred to medical examiner?

1X Yes 2□ No

26. Place of Death (Check only one)

Hospital:

1□ Inpatient

2X ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1X Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending investigation

6X Could not be determined

28a. Date of Injury (Month, Day, Year)

FOUND: 3-4-00

28b. Time of Injury

FOUND: 5:40

28c. Injury at Work?

1□ Yes 2X No

28d. Describe how injury occurred

UNKNOWN

28e. Location (Street and Number or Rural Route Number, City or Town, State)

UNKNOWN

29a. Certifier (Check only one)

1□ Certifying Physician

2X Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chukro

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 05, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chukro

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

MAR 09 2000

32. Registrar's Signature

Dennis J. Chukro

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09358

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEREMIAH JONES

2. Date of Death

March 1, 2000

3. Time of Death

10:15 AM

4a. Facility Name (If not institution, give street and number)

107 George Court

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

212-26-9829

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV 24, 1929

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
MD

10b. County

HARFORD

10c. City, Town or Location

HAURE DE GRACE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

107 George CT

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

Cornelius Jones

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Stewart

19a. Informant's Name/Relationship (Type, Print)

Cecelia Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1725 B Fountain Rock Way Edgewood MD 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARRISON Forest

Date

3-8-00 Owings Mills MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

D. Scott

22. Name and Address of Facility

BEARD Funeral Home
552 Lewis St Havre de Grace, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cancer of the throat

Due to (or as a consequence of):

3 Years

b. Chronic renal failure

Due to (or as a consequence of):

2 Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Anemia

Due to (or as a consequence of):

1 Year

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

D. Scott

29c. License number

D4C723

29d. Date signed (Month, Day, Year)

March 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type/Print)

KARITHANOM ISAAC, M.D., VA Maryland Health Care System, Perry Point, MD 21902

State
Registrar

31. Date filed (Month, Day, Year)

MAR 6 - 2000

32. Registrar's Signature

D. Scott

ORIGINAL

NAME KNOWN TO PHYSICIAN:
JEREMIAH JONES
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09359

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET L. JENKINS

2. Date of Death

Month Day Year
March 10, 2000

3. Time of Death

10:00 P.M.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

212-22-0255

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 19, 1925

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6007 Pleasant Drive

10f. Zip Code

21703

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

William

McKinney

18. Mother's Name (First, Middle, Maiden Summa)

Olive

Plemmons

19a. Informant's Name/Relationship (Type, Print)

Sarah Crigger / daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

5121 Mount Zion Rd./ Frederick, Maryland 21703

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Resthaven Memorial Gard. 3-14=00 Frederick, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike/ Frederick, MD 21702

23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE

1 yr

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

10 yrs

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

Investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street end Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D47611

29d. Date signed (Month, Day, Year)

March 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEIL W. ANDERSON MD 1475 TANZY AVE. FREDERICK MD 21702

State
Registrar

31. Date filed (Month, Day, Year)

MAR 14 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09360

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT ELLSWORTH KOLB				2. Date of Death Month Day Year MARCH 9, 2000		3. Time of Death 1:15 AM		
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 212-24-5512		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 75		8. Date of Birth (Month, Day, Year) April 18, 1924		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Frederick		10c. City, Town or Location Rocky Ridge		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9147 Longs Mill Road		10f. Zip Code 21778		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) farmer		16b. Kind of Business/Industry own farm		17. Father's Name (First, Middle, Last) Charles Peter Mathias Kolb		18. Mother's Name (First, Middle, Maiden Surname) Nettie Rebecca Ramsburg	
19a. Informant's Name/Relationship (Type, Print) Annie Kolb / wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9147 Longs Mill Rd, Rocky Ridge, MD 21778		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Creagerstown Cemetery		20c. Location - City or Town, State 3/11/00 Creagerstown, MD	
21. Signature of Funeral Service Licensee ► Jacqueline Krew		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 East Main Street, Thurmont, MD 21788		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Hepatorenal Syndrome Due to (or as a consequence of): b. Liver metastasis Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 1 week 75 yrs			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatorenal Syndrome Bronchitis pneumonia		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ► William O. Miller, MD		29c. License number D14373		29d. Date signed (Month, Day, Year) 3/1/2002			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William O. Miller, MD 804 Tenth Avenue Ave Frederick, MD 21701		31. Date filed (Month, Day, Year) MAR 10 2000		32. Registrar's Signature P. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09361

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCIS BRENDON KATZ				2. Date of Death Month Day Year MAR. 2, 2000		3. Time of Death 4:45 PM	
	4a. Facility Name (If not institution, give street and number) FREDERICK HEALTH CARE CENTER				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK	
Funeral Director	5. Social Security Number 219-34-5648		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) MAR. 5, 1939	
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County FREDERICK		10c. City, Town or Location FREDERICK	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 222 BROADWAY ST. APT. 204		10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RECEPTIONIST		16b. Kind of Business/Industry FREDERICK COM ACTION AGENCY			
	17. Father's Name (First, Middle, Last) KATZ BROWN				18. Mother's Name (First, Middle, Maiden Surname) MARIE MINES			
	19a. Informant's Name/Relationship (Type, Print) CLARK MYERS (BROTHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 176 WEST ALL SAINTS ST. FREDERICK MD. 21701			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREM.		20c. Date MAR. 10, 2000		20d. Location - City or Town, State BALT. MD.	
	21. Signature of Funeral Service Licensee <i>Tracy L. Rollins</i>				22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FRD. MD 21701			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic Carcinoma of the Bladder</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>William H. Convey, MD</i>				29c. License number D20395		29d. Date signed (Month, Day, Year) Mar 9, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H CONVEY, MD, 195 THOMAS JOHANSON DRIVE, FREDERICK, MD.							
State Registrar	31. Date filed (Month, Day, Year) MAR 09 2000				32. Registrar's Signature <i>P. Sparks</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

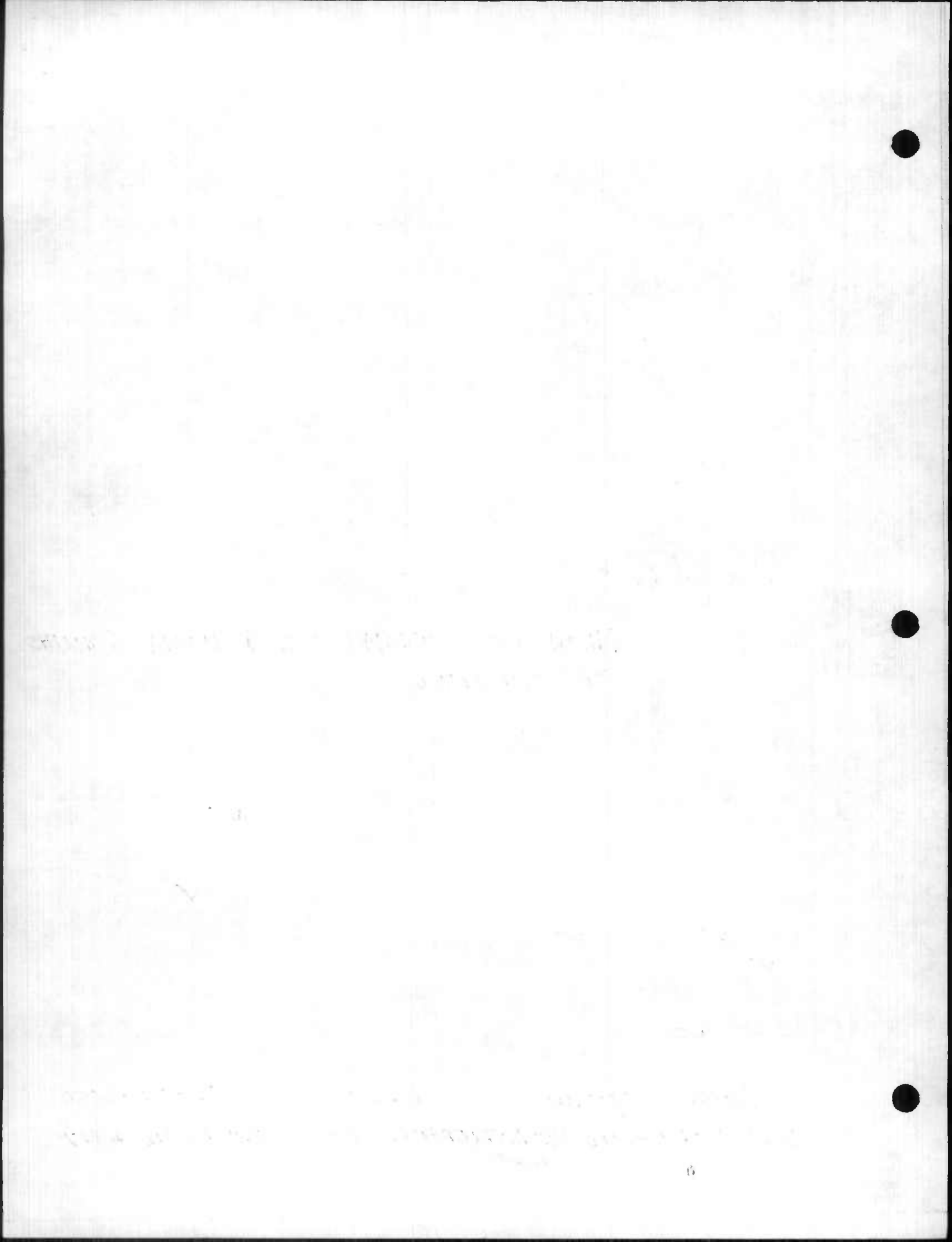
State of Maryland / Department of Health and Mental Hygiene

00 09362

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Kirk				2. Date of Death Month Day Year March 1, 2000		3. Time of Death 9:40 P.M.	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 092-12-0161	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 1, 1924		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 7414 Skyline Drive				10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Rafaelo Grimaldi				18. Mother's Name (First, Middle, Maiden Surname) Anna Abate			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) George Vincent Kirk/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 726 Springfield Lane, Frederick, Md. 21702			
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens		Date March 6, 2000		20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee Richard C. C. Basford M00021				22. Name and Address of Facility Keeney & Basford Funeral Home 106 East Church Street, Frederick, Maryland			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC NON-SMALL CELL CARCINOMA Due to (or as a consequence of): b. OF THE LUNG Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Victor M. Priego MD				29c. License number D23308		29d. Date signed (Month, Day, Year) 03-02-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTOR M. PRIEGO, MD 6410 ROCKLEDGE DR. #600 BETHESDA, MD 20817								
31. Date filed (Month, Day, Year) MAR 06 2000				32. Registrar's Signature P. Sparks				



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State of Maryland / Department of Health and Mental Hygiene

00 09363

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Arthur Lambert				2. Date of Death Month Day Year March 5 2000		3. Time of Death 11:40 PM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-24-6735		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 30, 1930	
	9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent								
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9328 White Road Avenue				10f. Zip Code 21702		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-53		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) salesman		16b. Kind of Business/Industry lumber company		
17. Father's Name (First, Middle, Last) Arthur Hench Lambert					18. Mother's Name (First, Middle, Maiden Surname) Louise E. Stup			
19a. Informant's Name/Relationship (Type, Print) Marion Lambert, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9328 White Rock Ave., Frederick, MD 21702				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date 3/9/2000		20c. Location - City or Town, State Frederick, Maryland	
21. Signature of Funeral Service Licensee Ryan M. Berger M00999				22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. EMPHYSEMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 10 YEARS								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Neil W. Warrick MD				29c. License number D47611		29d. Date signed (Month, Day, Year) MARCH 6, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL WARRICK MD 1475 TANY AVE #204 FREDERICK MD 21702								
31. Date filed (Month, Day, Year) MAR 08 2000				32. Registrar's Signature Benita B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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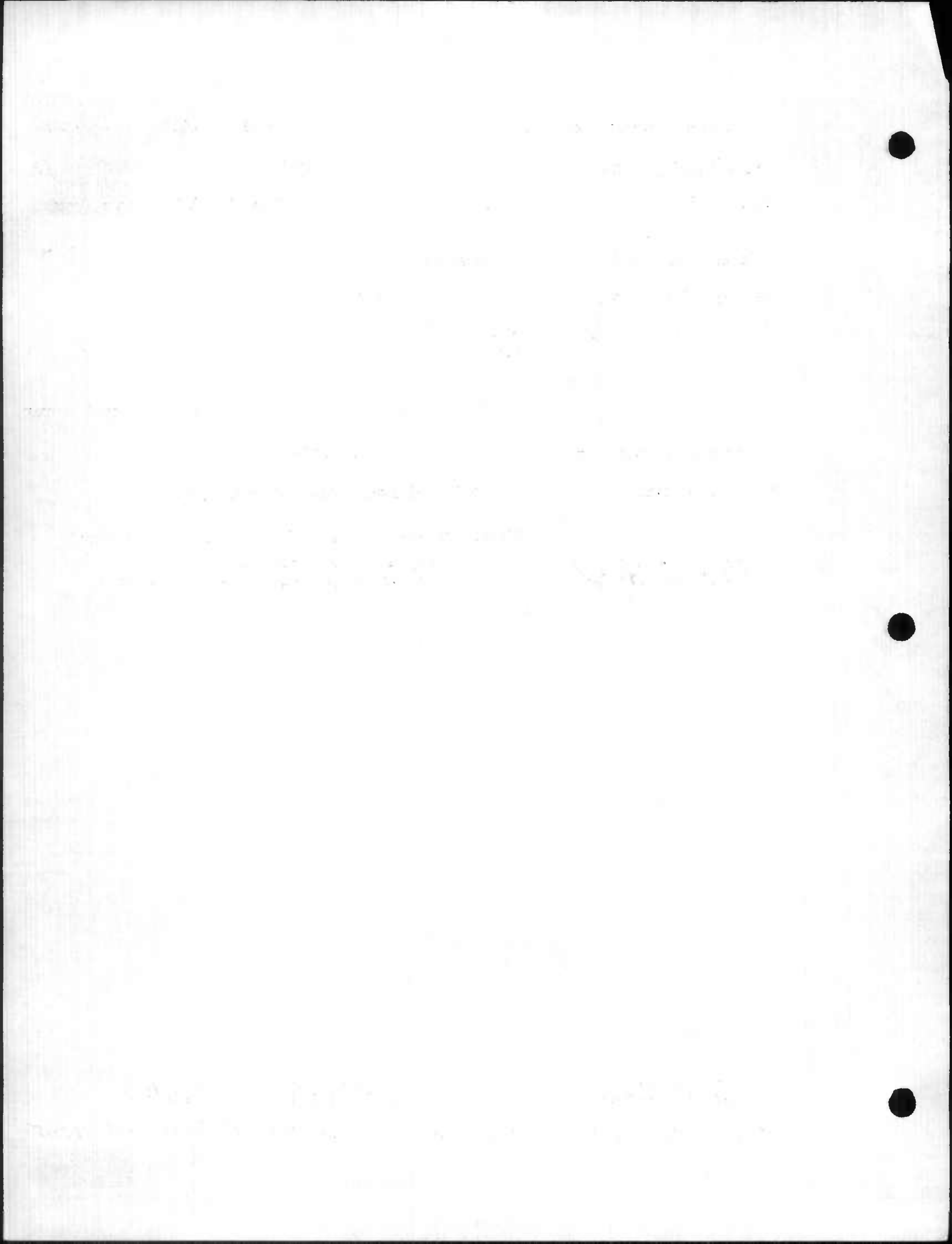
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09364

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Thomas LeMaire				2. Date of Death Month March Day 4 Year 2000		3. Time of Death 8:40PM	
	4a. Facility Name (If not Institution, give street and number) 1807 Harbinger Trail				4b. City, Town, or Location of Death Edgewood		4c. County of Death Harford	
Funeral Director	5. Social Security Number 211-28-9563		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 19, 1938	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County Harford		10c. City, Town or Location Edgewood		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 1807 Harbinger Trail				10f. Zip Code 21040		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Peace If Yes, Give Year or Dates: Time		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) 9 Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) A B Seaman		16b. Kind of Business/Industry Shipping Manufacturer		
17. Father's Name (First, Middle, Last) George Washington LeMaire					18. Mother's Name (First, Middle, Maiden Surname) Rosella (nmn) Gilmore			
19a. Informant's Name/Relationship (Type, Print) Polly J. LeMaire				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 Harbinger Trail, Edgewood, MD 21040				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 3-8-00		20c. Location - City or Town, State Towson, Maryland		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiomyopathy Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Diabetes mellitus Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular disease						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D35199		29d. Date signed (Month, Day, Year) 3/6/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ERIC B. BASS, MD 1830 E. Monument St, Rm 8068 Baltimore MD 21205								
31. Date filed (Month, Day, Year) MAR 7 - 2000		32. Registrar's Signature <i>[Signature]</i>						



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09365

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Blaine Wilbur Meyers					2. Date of Death Month Day Year MARCH 7 2000		3. Time of Death 8:34 AM			
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital					4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany			
Funeral Director	5. Social Security Number 215-36-8806		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 7, 1939		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD			10b. County Garrett			10c. City, Town or Location Friendsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 4510 Accident-Friendsville Road					10f. Zip Code 21531		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver & Heavy Equipment Operator			16b. Kind of Business/Industry Meyers Lumber			
17. Father's Name (First, Middle, Last) Cubert Meyers					18. Mother's Name (First, Middle, Maiden Surname) Ethel Friend						
19a. Informant's Name/Relationship (Type, Print) Lilly Meyers/Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4510 Accident-Friendsville Rd., Friendsville, MD 21531						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sand Spring Cem, March 9, 2000			Date March 9, 2000		20c. Location - City or Town, State Friendsville, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Newman Funeral Homes, P.A., 179 Miller Street P.O. Box 275, Grantsville, MD 21536						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intracerebral Hemorrhage Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Arteriosclerosis Pneumonia										Approximate Interval Between Onset and Death 21 day 15 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerosis Pneumonia								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 					29c. License number D12532		29d. Date signed (Month, Day, Year) MARCH 7, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Breza, M.D., 912 Seton Drive Cumberland MD 21502											
31. Date filed (Month, Day, Year) MAR - 8 2000			32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09366

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vauda Beulah Meilinger						2. Date of Death Month Day Year March 1, 2000		3. Time of Death 6:30 PM	
	4a. Facility Name (If not institution, give street and number) 3193 Pleasant Valley Road						4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett	
Funeral Director	5. Social Security Number 216-18-1247		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 21, 1903		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Garrett		10c. City, Town or Location Oakland				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3193 Pleasant Valley Road				10f. Zip Code 21550		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LPN/Homemaker			16b. Kind of Business/Industry Nursing Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Calvin H. Glotfelty						18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Echerd			
	19a. Informant's Name/Relationship (Type, Print) Amelia C. Wolf/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 151 Smith Drive, Oakland, Md. 21550			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery		Date 3/4/00		20c. Location - City or Town, State Swanton, Md.			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Heart Disease Due to (or as a consequence of): b. CVA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Years Years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier 						29c. License number D30035		29d. Date signed (Month, Day, Year) 3/2/2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Donald R. Richter, MD 1533 Memorial Drive, Oakland, Maryland 21550									
31. Date filed (Month, Day, Year) MAR - 6 2000										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Amended Line #8 3-7-00

Certificate of Death HCHD CAJ

Reg. No.

00 09367

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DWAYNE ALVIN MACKLIN

2. Date of Death

March 01, 2000

Day Year

3. Time of Death

1:11 P.M.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

217-11-2141

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

26 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07 23 73

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

JESSUP

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8124 ASPENWOOD WAY

10f. Zip Code

20794

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STUDIO ENGINEER

16b. Kind of Business/Industry

MUSIC

17. Father's Name (First, Middle, Last)

ALVIN WARDELL MACKLIN

18. Mother's Name (First, Middle, Maiden Surname)

MESMA HARDING

19a. Informant's Name/Relationship (Type, Print)

Angelica MACKLIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8124 ASPENWOOD WAY JESSUP MD 20794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Cem

Data

20c. Location - City or Town, State

39-00 Baltimore, MD

21. Signature of Funeral Service Licensee

Lisa Scott

22. Name and Address of Facility

BEARD FUNERAL HOME
552 Lewis St. Mount Airy, NC 27025

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot Wound to Back of Chest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☒ Homicide

28a. Date of Injury (Month, Day, Year)

3/1/00

28b. Time of Injury

1230 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1750 Blk Meade Circle 40

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dwayne Alvin Macklin

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 02, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. ALVIN MACKLIN, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

March 3 - 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09368

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys Irene Millen				2. Date of Death Month Day Year March 6, 2000				3. Time of Death 10:25 AM					
	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Home				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick					
Funeral Director	5. Social Security Number 220-07-4948		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) June 23, 1910		9. Birthplace (State or Foreign Country) Maryland					
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	10e. Street and Number 412 East Ninth Street				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping				16b. Kind of Business/Industry College					
	17. Father's Name (First, Middle, Last) Orville Shifler				18. Mother's Name (First, Middle, Maiden Surname) Barbara Sensenbaugh									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Orville Yingling, Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 East Ninth St., Frederick, Md. 21701									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, March 9, 2000		Date March 9, 2000		20c. Location - City or Town, State Frederick, Maryland							
	21. Signature of Funeral Service Licensee Richard E. Hyatt MO0255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 5 yrs.			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29c. License number D 13971		29d. Date signed (Month, Day, Year) March 8, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Maryland 21701													
State Registrar	31. Date filed (Month, Day, Year) MAR 08 2000		32. Registrar's Signature B. Sparks											

W. J. Brown

W. J. Brown

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09369

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stella Marshall

2. Date of Death
Month Day Year
March 4, 20003. Time of Death
9:10 AMFuneral
Director

4a. Facility Name (If not Institution, give street and number)

Montgomery General Rehabilitation Center

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

214-42-4225

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 17, 1906

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Clarksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

25200 Clarksburg Road

10f. Zip Code

20871

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4or 5+)

18e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Jacob Ihrig

18. Mother's Name (First, Middle, Maiden Surname)

Johanna Koller

19a. Informant's Name/Relationship (Type, Print)

Dorothy M. Federline - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2319 Oak Drive, Ijamsville, Maryland 21754

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Clarksburg Methodist Cem. 3/8/00

Date

20c. Location - City or Town, State

Clarksburg, Maryland

21. Signature of Funeral Service Licensee

Ruth L. Williams

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland

20872-0117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or renal failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Staph Aureus Sepsis

11 Days

Due to (or as a consequence of):

b. Leaking Aortic Arch Aneurysm

3 Days

Due to (or as a consequence of):

c. Congestive Heart Failure

5 Years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Center

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28e. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bennett Morrison M.D.

29c. License number

D47682

29d. Date signed (Month, Day, Year)

March 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett Morrison, M.D. 2901 Olney-Sandy Spring Road, Olney, Maryland 20832

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09370

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LORENA HELEN MOBERLY				2. Date of Death Month Day Year MARCH 4, 2000		3. Time of Death 6:35 AM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 219-20-3362		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 11, 1921	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Adamstown	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5509 Adamstown Road		10f. Zip Code 21710		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) never employed		16b. Kind of Business/Industry				
17. Father's Name (First, Middle, Last) Charles B. Smith				18. Mother's Name (First, Middle, Maiden Surname) Lorena May Gwin				
19a. Informant's Name/Relationship (Type, Print) Joy Clem, niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5679 Mountville Road, Adamstown, Maryland 21710				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Date 3/7/2000		20d. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee Ryan M. Beyer		22. Name and Address of Facility Keeney and Basford Funeral Home		22. Address of Facility 106 East Church Street, Frederick, MD 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Embolism Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 12 hrs						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. M. D.		29c. License number P30838		29d. Date signed (Month, Day, Year) 03/07/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 915 Tollhouse Ave. Ste. 307, Frederick, MD								
31. Date filed (Month, Day, Year) MAR 08 2000		32. Registrar's Signature Benjamin P. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09371

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) REAN JAMES MILLER				2. Date of Death Month Day Year March 2, 2000		3. Time of Death 7:45 p.m.																		
	4a. Facility Name (If not institution, give street and number) 13850 West Old Baltimore Road				4b. City, Town, or Location of Death Boyds		4c. County of Death Montgomery																		
Funeral Director	5. Social Security Number 213-44-7167	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 10, 1946		9. Birthplace (State or Foreign Country) Virginia																	
	Usual Residence of Decedent																								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Boyds		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
	10e. Street and Number 13850 W. Old Baltimore Road				10f. Zip Code 20841		10g. Citizen of What Country? United States																		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white																		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner/operator		16b. Kind of Business/Industry Miller Excavating Co.																				
	17. Father's Name (First, Middle, Last) Rean Statler Miller				18. Mother's Name (First, Middle, Maiden Surname) Hannah Marjorie Turner																				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Guelda Miller / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13850 W. Old Baltimore Rd., Boyds, MD 20841																				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Boyds Presb. Church Cem.		20c. Location - City or Town, State 3/6/00 Boyds, Maryland																				
	21. Signature of Funeral Service Licensee Garguino KKK				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702																				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. GENERALISED CARCINOMATOSIS</td> <td>2 WEEKS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. ADVANCED MULTIPLE MYELOMA</td> <td>3 MONTHS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. GENERALISED CARCINOMATOSIS	2 WEEKS	Due to (or as a consequence of):		b. ADVANCED MULTIPLE MYELOMA	3 MONTHS	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.		Due to (or as a consequence of):		d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. GENERALISED CARCINOMATOSIS	2 WEEKS																							
	Due to (or as a consequence of):																								
	b. ADVANCED MULTIPLE MYELOMA	3 MONTHS																							
	Due to (or as a consequence of):																								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.																								
	Due to (or as a consequence of):																								
	d.																								
	Due to (or as a consequence of):																								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D45274		29d. Date signed (Month, Day, Year) March 3, 2000																			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cho Maung Kaiser Permanente 10810 Connecticut Ave Kensington MD 20895																									
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature [Signature]																							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended#10b 3/17/2000 Ks
 Amended#1 3/14/2000 State of Maryland / Department of Health and Mental Hygiene FCHD,KS 00 09372
 Amended item#15,18 3/06/2000 FCHD Certificate of Death KS Reg. No.

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Charles Allen Myers Edward Allen Myers				2. Date of Death Month Day Year MAR. 2, 2000		3. Time of Death 5:29 pm	
4a. Facility Name (If not institution, give street and number) WASHINGTON ADV. HOSPITAL				4b. City, Town, or Location of Death TACOMA PARK		4c. County of Death PRINCE GEORGE	
5. Social Security Number 213-56-2429		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 3, 1950	9. Birthplace (State or Foreign Country) MD.
Usual Residence of Decedent							
10a. State MD.		10b. County CARROLL Howard		10c. City, Town or Location MT. AIRY		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 1140 SHAFFERSVILLE RD.				10f. Zip Code 21771		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 10		College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE / DIETICIAN		16b. Kind of Business/Industry MONTGOMERY CN SCHOOL SYSTEM	
17. Father's Name (First, Middle, Last) CHARLES E. MYERS				18. Mother's Name (First, Middle, Maiden Surname) KATHERINE LUBY Kathryn Luby			
19a. Informant's Name/Relationship (Type, Print) KATHRYN MYERS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State) 1140 SHAFFERSVILLE RD. MT. AIRY MD			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SIMPSON UMC CEM.		Date MAR. 7, 2000		20c. Location - City or Town, State POPLAR SPRINGS MD	
21. Signature of Funeral Service Licensee ► Gary L. Rollins				22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST FRED. MD. 21701			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death One hour Ten years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. renal failure Diabetes mellitus Peripheral vascular disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier ► Joann Orquhart MD				29c. License number D 25881		29d. Date signed (Month, Day, Year) March 3, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9711 medical center Drive Rockville Md 20850							
31. Date filed (Month, Day, Year) MAR 06 2000				32. Registrar's Signature ► [Signature] P. Sparks			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09373

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES EDWARD O'NEILL, JR.				2. Date of Death Month Day Year March 9, 2000		3. Time of Death 4:30PM	
	4a. Facility Name (If not institution, give street and number) 12794 Waldorf Forest RD				4b. City, Town, or Location of Death Waldorf		4c. County of Death Charles	
Funeral Director	5. Social Security Number 213-46-5545		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) October 25, 1947	
	9. Birthplace (State or Foreign Country) Virginia							
Usual Residence of Decedent								
10a. State MD		10b. County Charles		10c. City, Town or Location Waldorf			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 12794 Waldorf Forest Road				10f. Zip Code 20601		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1967-1973		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steamfitter			16b. Kind of Business/Industry Union	
17. Father's Name (First, Middle, Last) James Edward O'Neill, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Dorothy May Elliott				
19a. Informant's Name/Relationship (Type, Print) Jean O'Neill/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12794 Waldorf Forest Rd. Waldorf, MD 20601				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols FH 3/14/00 Charlotte Hall, MD.		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee  M00945				22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. P.O. Box 128 Charlotte Hall, MD 20622				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung CA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  Krishan Mathur				29c. License number D28352		29d. Date signed (Month, Day, Year) 3/13/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Krishan Mathur, MD 105 La Grange Ave La Plata MD 20646								
31. Date filed (Month, Day, Year) MAR 13 2000		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09374

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FREDA NELLIE PAUGH

2. Date of Death

Month Day Year
MARCH 7 2000

3. Time of Death

1830 Hrs

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

236-03-6039

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 15 1909

9. Birthplace (State or Foreign Country)

W.Va

Usual Residence of Decedent

10a. State
W.Va

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

500 Carskadan Ln

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Housewife

17. Father's Name (First, Middle, Last)

William Sherwood

18. Mother's Name (First, Middle, Maiden Surname)

Emma Taylor

19a. Informant's Name/Relationship (Type, Print)

Janet Lee Aabury

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4734 Belle Fort Rd. Pikesville, Md 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Kalbaugh Cemetery

Date

Mar 10 '00

20c. Location - City or Town, State

Elk Garden WVa

21. Signature of Funeral Service Licensee

David A. Burdock

22. Name and Address of Facility

David A. Burdock Funeral Home

710 Church St Kitzmiller, Md 21538

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE PULMONARY EMBOLISM

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LEFT HIP ARTHROPLASTY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Ravi MD, NHC

29c. License number

D37333

29d. Date signed (Month, Day, Year)

MARCH 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. RAVI MD, NHC, BALTO. MD 21133

31. Date filed (Month, Day, Year)

MAR - 9 2000

32. Registrar's Signature

Benjamin B. Spahr

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09375

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clara Luare Pasternak				2. Date of Death Month Day Year March 5, 2000		3. Time of Death 10:10 pm	
	4e. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-10-2671		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) May 14, 1914	
	Usual Residence of Decedent		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Linthicum	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 715 Evelyn Avenue		10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Albert Ira Fogle				18. Mother's Name (First, Middle, Maiden Surname) Mary Virginia Esworthy			
	19a. Informant's Name/Relationship (Type, Print) Stephen W. Haller/Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2185 E Greenleaf Drive, Frederick, Maryland 21702			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Olivet Cemetery		Date Mar 8, 2000		20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee <i>Helen Roberson</i>		22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. EMPHYSEMA Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 10 yrs 10 yrs			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Neil Wardekar</i>		29c. License number D47611	
					29d. Date signed (Month, Day, Year) March 6, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL WARDEKAR MD, 1475 LANEY AVE #204 FREDERICK MD 21702							
31. Date filed (Month, Day, Year) MAR 07 2000				32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09376

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE PORTER				2. Date of Death Month Day Year MARCH 2, 2000		3. Time of Death 1:45 PM														
	4a. Facility Name (If not institution, give street and number) 13349 BOTTOM ROAD				4b. City, Town, or Location of Death MT. AIRY		4c. County of Death FREDERICK														
Funeral Director	5. Social Security Number 219-20-9991		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) March 18, 1902														
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Mt. Airy														
Usual Residence of Decedent																					
10a. State Maryland			10b. County Frederick			10c. City, Town or Location Mt. Airy															
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number 13349 Bottom Road			10f. Zip Code 21771															
10g. Citizen of What Country? United States			11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:															
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) -															
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) dairy farmer			16b. Kind of Business/Industry dairy farm			17. Father's Name (First, Middle, Last) Arch Porter															
18. Mother's Name (First, Middle, Maiden Surname) Lucretia unknown			19a. Informant's Name/Relationship (Type, Print) Janet Dixon			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13349 Bottom Road, Mt. Airy MD 21771															
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Locust Grove Cemetery			20c. Location - City or Town, State 3/6/00 Mt. Airy, Maryland															
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, MD 21771																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td><i>Coronary Heart Failure</i></td> <td>Approximate Interval Between Onset and Death <i>years</i></td> </tr> <tr> <td>b.</td> <td><i>Coronary artery disease</i></td> <td><i>years</i></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Coronary Heart Failure</i>	Approximate Interval Between Onset and Death <i>years</i>	b.	<i>Coronary artery disease</i>	<i>years</i>	c.			d.		
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Coronary Heart Failure</i>	Approximate Interval Between Onset and Death <i>years</i>																		
	b.	<i>Coronary artery disease</i>	<i>years</i>																		
	c.																				
	d.																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined																					
28a. Date of Injury (Month, Day Year)																					
28b. Time of Injury M																					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
28d. Describe how injury occurred																					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																					
28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier <i>[Signature]</i> M.D.																					
29c. License number 026499																					
29d. Date signed (Month, Day, Year) 3-3-00																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ronald E. Miller, 4 Culwell Dr, Mt. Airy, MD 21771																					
31. Date filed (Month, Day, Year) MAR 03 2000																					
32. Registrar's Signature <i>[Signature]</i> P. Sparks																					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 23a per md G782 4/15/00 State of Maryland / Department of Health and Mental Hygiene
 Amended #7 3/6/00 FCHD Amended #7 Certificate of Death 3/14/2000 Reg. No. FCHD, KS

00 09377

Baltimore, Maryland 21215-0020
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Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) GRACE PAGE		2. Date of Death Month FEB. Day 29 Year 2000		3. Time of Death 10:45pm
4a. Facility Name (If not institution, give street and number) CITIZENS NURSING HOME		4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK
5. Social Security Number 216-14-6411	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	8. Date of Birth (Month, Day, Year) MAR. 2, 1907	9. Birthplace (State or Foreign Country) MD.
Usual Residence of Decedent				
10a. State MD.	10b. County FREDERICK	10c. City, Town or Location FREDERICK		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 1421 TANEY AVE. APT. 506		10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FAMILY CARE TAKER		16b. Kind of Business/Industry PRIVATE FAMILY		
17. Father's Name (First, Middle, Last) WILLIAM FOREMAN		18. Mother's Name (First, Middle, Maiden Surname) HARRIET G. LARKINS		
19a. Informant's Name/Relationship (Type, Print) HELEN BONNER (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5310 KANSAS AVE. NW WASHINGTON, D.C. 20011		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRVIEW CEM.		20c. Location - City or Town, State MAR. 6, 2000 FRED. MD.
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST FRED. MD. 21701		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Severe Dementia Hypertension Diabetes mellitus				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
23c. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No				
24. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D51643		29d. Date signed (Month, Day, Year) 3/3/00
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 170 Thomas Johnson Drive #100 Frederick MD 21702				
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature <i>[Signature]</i>		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09378

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Winfield Romesburg				2. Date of Death Month Day Year March 9, 2000		3. Time of Death 6:23PM		
	4a. Facility Name (If not institution, give street and number) Dennett Road Manor Nursing Home				4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett		
Funeral Director	5. Social Security Number 213-22-2910		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 3, 1925		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1849 Portship Road		10f. Zip Code 21222		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Boilermaker		16b. Kind of Business/Industry Ship Yard					
17. Father's Name (First, Middle, Last) Ralph Mason Romesburg, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Grace Marie Bowman					
19a. Informant's Name/Relationship (Type, Print) Betty E. Romesburg/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1849 Portship Road, Baltimore, Md. 21222					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Thayerville Cemetery		20c. Location - City or Town, State Oakland, Md.		20d. Date 3/12/00			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) atherosclerotic cerebrovascular disease								Approximate Interval Between Onset and Death 1 year	
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequitally list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last diabetes mellitus, urinary tract infection									
24. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. diabetes mellitus, urinary tract infection								25. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
26. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								27. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
28. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		29a. Date of Injury (Month, Day, Year)		29b. Time of Injury M		29c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		29d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D25759		29d. Date signed (Month, Day, Year) March 9, 2000			
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Walter K. Naumann, M.D., PO Box 247, Accident MD 21520									
31. Date filed (Month, Day, Year) MAR 10 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09379

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carrie Mae Rice				2. Date of Death Month Day Year March 8, 2000				3. Time of Death 2:08 p.m.	
	4a. Facility Name (If not institution, give street and number) 10229 Bethel Road				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-07-4949		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 9, 1922		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 10229 Bethel Road		10f. Zip Code 21702		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry own home				
	17. Father's Name (First, Middle, Last) John Russell Huff				18. Mother's Name (First, Middle, Maiden Surname) Eleanor Wetzell					
	19a. Informant's Name/Relationship (Type, Print) Susan O'Toole / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6022 Mountindale Rd., Thurmont, MD 21788					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Union Chapel Cemetery		20c. Date 3/11/00		20d. Location - City or Town, State Libertytown, MD			
	21. Signature of Funeral Service Licensee <i>Jaqueline Kren</i>				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Small cell lung carcinoma</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>> 2 years</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Actual febrillation</i>								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>A. J. Sparks</i>				29c. License number D 26516		29d. Date signed (Month, Day, Year) MARCH 9 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Alton J. Gilmer</i> 1475 TANEY AVE FRED MD 21702										
31. Date filed (Month, Day, Year) MAR 10 2000		32. Registrar's Signature <i>P. Sparks</i>								

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 09381

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Ann Stockton				2. Date of Death Month Day Year March 10, 2000				3. Time of Death 1315	
	4a. Facility Name (If not institution, give street and number) Homewood Retirement Center				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 453-82-0090		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) May 27, 1915		9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 6888 Crabapple Court				10f. Zip Code 21703		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Martin Kalafut				18. Mother's Name (First, Middle, Maiden Surname) Mary Klikosowian					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Lou Musser, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 East Church Street, Frederick, Maryland 21701					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory, or other place) Mount Olivet Cemetery, March 14, 2000		Date March 14, 2000		20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee Richard E. May M00255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMER'S DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Neil Warrick MD				29c. License number D47611			29d. Date signed (Month, Day, Year) March 13, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL WARRICK MD, 1475 TANEX AVE #204 FREDERICK, MD 21702										
State Registrar	31. Date filed (Month, Day, Year) MAR 13 2000				32. Registrar's Signature P. Sparks					

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State of Maryland / Department of Health and Mental Hygiene

00 09380

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George William Robertson, Sr.				2. Date of Death Month March Day 10 Year 2000		3. Time of Death 10:01AM	
	4a. Facility Name (If not institution, give street and number) 8531 Taurus Lane				4b. City, Town, or Location of Death Port Tobacco		4c. County of Death Charles	
Funeral Director	5. Social Security Number 218-30-3356		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 12, 1930	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD		10b. County Charles		10c. City, Town or Location Port Tobacco			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8531 Taurus Lane				10f. Zip Code 20677		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Restaurateur		16b. Kind of Business/Industry Restaurant		
17. Father's Name (First, Middle, Last) Albert Waesche					18. Mother's Name (First, Middle, Maiden Surname) Rebecca Huber			
19a. Informant's Name/Relationship (Type, Print) George Robertson, Jr./Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9520 Bel Alton Newtown Rd. Bel Alton, MD 20611			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Christ Church		Date 3/15/00		20c. Location - City or Town, State Wayside, MD.	
21. Signature of Funeral Service Licensee M00945 <i>David C. Echols</i>					22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Carcinoma of Gallbladder Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Henry J. Burke MD			29c. License number D01009		29d. Date signed (Month, Day, Year) 3-11-2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henry Burke, MD. P.O. Box 2539 La Plata, MD 20646								
31. Date filed (Month, Day, Year) MAR 13 2000			32. Registrar's Signature <i>Benjamin B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09382

Amended item#7&8 3/13/2000 FCHD,KS Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUISE ALVA STACKHOUSE				2. Date of Death Month Day Year MARCH 10, 2000		3. Time of Death 2:50 A.M.	
	4a. Facility Name (If not institution, give street and number) CITIZENS NURSING HOME OF FREDERICK				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK	
Funeral Director	5. Social Security Number 217-18-8788		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 74 Yrs.		8. Date of Birth (Month, Day, Year) APR. 24, 1915	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MD CREAGERSTOWN, APR. 24, 1925					
To Be Completed by Funeral Director	10a. State MD		10b. County FREDERICK		10c. City, Town or Location THURMONT		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 15945 ST. ANTHONY'S ROAD				10f. Zip Code 21788		10g. Citizen of What Country? U. S. A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOOD SERVICE		16b. Kind of Business/Industry MT. ST. MARY'S COLLEGE			
	17. Father's Name (First, Middle, Last) PAUL YINGLING				18. Mother's Name (First, Middle, Maiden Surname) FRENCE JENKINS			
	19a. Informant's Name/Relationship (Type, Print) KAREN L. MATTHEWS/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8331A OLD KILN RD., THURMONT, MD. 21788			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RESTHAVEN MEMORIAL GARDENS 3/12/00		20c. Location - City or Town, State FREDERICK, MD.			
	21. Signature of Funeral Service Licensee <i>John M. Skiles</i>				22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Coronary Artery Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Robert L. Kaufman</i>				29c. License number D-13971		29d. Date signed (Month, Day, Year) 3/10/2000		
30. Name and address of person who completes cause of death (Item 23a) (Type, Print) ROBERT L. KAUFMAN, 300 W-9TH ST FREDERICK, MD 21701								
31. Date filed (Month, Day, Year) MAR 10 2000		32. Registrar's Signature <i>Robert L. Kaufman</i>						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09383

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl Agatha Stockman				2. Date of Death Month Day Year March 9, 2000				3. Time of Death 9:20 AM	
	4a. Facility Name (If not institution, give street and number) Vindobona Nursing Home				4b. City, Town, or Location of Death Braddock Heights				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 217-42-9613		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 27, 1901		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick		10c. City, Town or Location Jefferson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 4014 H Mountville Road				10f. Zip Code 21755	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home				17. Father's Name (First, Middle, Last) David Stockman	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Clara Belle Zimmerman				19a. Informant's Name/Relationship (Type, Print) Mrs. Ruth S. Ingram, sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4014 H Mountville Rd., Jefferson, Maryland 21755	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Lukes Cemetery, March 11, 2000				20c. Location - City or Town, State Feagaville, Md.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Richard E. Gray M00255				22. Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Maryland 21701				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier J. P. Henry MD				29c. License number D35553	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) March 9, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. P. Henry 609th Ave Brunswick, MD 21716				31. Date filed (Month, Day, Year) MAR 10 2000	
	32. Registrar's Signature B. Sparks				33. Date of Death March 9, 2000				34. Registrar's Signature B. Sparks	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09384

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY STORR STULL

2. Date of Death

Month Day Year
MARCH 9, 2000

3. Time of Death

2:30 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

217-18-8422

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 25, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9822 Hansonville Road

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
2

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

assistant sales manager

16b. Kind of Business/Industry

Frederick
Brickworks

17. Father's Name (First, Middle, Last)

Harry C. Stull

18. Mother's Name (First, Middle, Maiden Summa)

Elgie Mae Storr

19a. Informant's Name/Relationship (Type, Print)

Betty C. Stull / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9822 Hansonville Rd., Frederick, MD 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mount Olivet Cemetery

Date

3/13/00

20c. Location - City or Town, State

Frederick, MD

21. Signature of Funeral Service Licensee

► Jacqueline Kren

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.
1621 Opossumtown Pike, Frederick, MD 2170223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Congestive Heart Failure
Due to (or as a consequence of):

2 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Coronary Artery Disease
Due to (or as a consequence of):

Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Prostate Cancer

Stroke

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

► Kanan Hudhud

29c. License number

D 41866

29d. Date signed (Month, Day, Year)

March 9, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanan Hudhud, MD 801 Tollhouse Avenue, FI FREDERICK, MD 21701

State
Registrar

31. Date filed (Month, Day, Year)

MAR 10 2000

32. Registrar's Signature

► Kanan Hudhud

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09385

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leona Smoot				2. Date of Death Month Day Year March 5, 2000				3. Time of Death 1:00 p.m.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick		
Funeral Director	5. Social Security Number 236-28-5465		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) April 3 1922		9. Birthplace (State or Foreign Country) Millville WV		
	Usual Residence of Decedent										
10a. State MD		10b. County Frederick		10c. City, Town or Location Brunswick				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 39 East "C" Street				10f. Zip Code 21716				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian				16b. Kind of Business/Industry National Geographic Society			
17. Father's Name (First, Middle, Last) William E. Hardy				18. Mother's Name (First, Middle, Maiden Surname) Greta Elizabeth Ross							
19a. Informant's Name/Relationship (Type, Print) Carole A. Whittington, Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 Spring Garden Court, Antioch, TN 37013							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rosedale Cemetery		Date 3/10/2000		20c. Location - City or Town, State Martinsburg, WV					
21. Signature of Funeral Service Licensee Barbara A. Williams, Owner				22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. EXACERBATION OF EMPHYSEMA Due to (or as a consequence of):										1 WEEK	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. PNEUMONIA - LEFT LOWER LOBE OF LUNG Due to (or as a consequence of):										2 DAYS	
c. ACUTE ISCHEMIA OF LEGS (BILATERAL) Due to (or as a consequence of):										1 DAY	
d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Neil Wardekm				29c. License number D47611				29d. Date signed (Month, Day, Year) MARCH 5, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL WARDEKM, MD 1475 TANNY AVE. #204 FREDERICK, MD 21702											
31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature [Signature]									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09386

Amended item#26 3/06/2000, FCHD KS

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL LOUISE SMITH

2. Date of Death

Month Day Year
MARCH 3, 2000

3. Time of Death

8:49 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

215-20-9477

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 11, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4216 Lime Kiln Road

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeping Department

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Grover

Dixon

18. Mother's Name (First, Middle, Maiden Surname)

Adele

Buzzard

19a. Informant's Name/Relationship (Type, Print)

Mrs. Janet Linton, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4216 Lime Kiln Road, Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery, March 6, 2000

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

► *Keeney*

MO0255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home
106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumonia*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ LOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *[Signature]* M.D.

29c. License number

D34303

29d. Date signed (Month, Day, Year)

Nov 6 03 - 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRFAN W. HASSEN 801 TOLL HOUSE AVE, FREDERICK, Md.

State
Registrar

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

► *[Signature]*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09387

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phyllis Ethel Shrader				2. Date of Death Month March Day 1 Year 2000		3. Time of Death 10:18pm	
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 215-36-3489		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 8, 1918	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Mt. Airy	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No				10e. Street and Number 201 Watersville Road Apt. 42			
	10f. Zip Code 21771				10g. Citizen of What Country? United States			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Ike Turner				18. Mother's Name (First, Middle, Maiden Surname) Virginia Reed			
	19a. Informant's Name/Relationship (Type, Print) Wanda Wells/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13870 Old National Pike, Mt. Airy, Maryland 21771			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 3/3		20c. Location - City or Town, State Frederick, Maryland		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Small Cell CARCINOMA OF Lung					
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Roman K. Galun III		29c. License number D31660		29d. Date signed (Month, Day, Year) 3/2/2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Roman K. Galun III MD 295 STOVER AVENUE WESTMINSTER, MD							
	31. Date filed (Month, Day, Year) MAR 03 2000		32. Registrar's Signature 					

ORIGINAL

Handwritten signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09388

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nana Y. Tenly						2. Date of Death Month Day Year March 2, 2000			3. Time of Death 1710					
	4a. Facility Name (If not institution, give street and number) Laurelwood Nursing Home						4b. City, Town, or Location of Death Elkton			4c. County of Death Cecil					
Funeral Director	5. Social Security Number 219-28-3653		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 23, 1902		9. Birthplace (State or Foreign Country) North Carolina						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State MD		10b. County Harford		10c. City, Town or Location Churchville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 3116 Aldino Road				10f. Zip Code 21028			10g. Citizen of What Country? U.S.A.							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry In home							
	17. Father's Name (First, Middle, Last) David L. Yonce						18. Mother's Name (First, Middle, Maiden Surname) Polly Lawrence								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) M. Adalee Cosenza (Daughter)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3114 Aldino Road, Churchville, MD 21028								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gardens		20c. Location - City or Town, State Aberdeen, Maryland		20d. Date 3/6/00						
	21. Signature of Funeral Service Licensee <i>Kenneth B. Cargo</i>						22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <i>Septis</i> Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death 3 days 1 week </td> </tr> <tr> <td>b. <i>Urinary Tract Infection</i> Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>Septis</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 days 1 week	b. <i>Urinary Tract Infection</i> Due to (or as a consequence of):	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>Septis</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 days 1 week													
	b. <i>Urinary Tract Infection</i> Due to (or as a consequence of):														
	c. Due to (or as a consequence of):														
	d. Due to (or as a consequence of):														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's disease</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier <i>Monte Makous, MD</i>						29c. License number 0-44783		29d. Date signed (Month, Day, Year) March 3, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Monte Makous, MD 111 West High Street, Elkton, MD 21924</i>															
31. Date filed (Month, Day, Year) MAR 6 - 2000				32. Registrar's Signature <i>Anna B. Sparks</i>											

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09389

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARTHA LOUISE THOBOIS

2. Date of Death

Month Day Year
March 10, 2000

3. Time of Death

1249

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

579-62-7066

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 4, 1914

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Walkersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10110 Kelly Road

10f. Zip Code

21793

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert Petran

18. Mother's Name (First, Middle, Maiden Surname)

Mary Havlicek

19a. Informant's Name/Relationship (Type, Print)

Albert E. Thoboies (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10110 Kelly Road, Walkersville, Maryland 21793

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mount Olivet Cemetery

Date

3/14/00

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
1201 NORTH MARKET ST., FREDERICK, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Cardiac Arrest

Due to (or as a consequence of):

b.

Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Minutes

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D41866

29d. Date signed (Month, Day, Year)

March 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanan Hudhud, MD 801 Toll House Avenue, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

MAR 14 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2008.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09390

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA RIEKSTS VITOLS

2. Date of Death
Month Day Year
MARCH 8, 2000
3. Time of Death
4:20 AMFuneral
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health of Southern Maryland

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

395-30-0439

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

105

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

June 3 1894

9. Birthplace (State or Foreign Country)

Latvia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9211 Steuart Lane

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Janis Vitols

18. Mother's Name (First, Middle, Maiden Summa)

Anna Gaics Vitols

19a. Informant's Name/Relationship (Type, Print)

Ivor Kaklins (Grandson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 Welland Road Brookline, MA 02445

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 3-9-00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

MO0173

22. Name and Address of Facility

Eberwein Funeral Services
4433 White Pls 1a White Pls, MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Multi System Failure*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Sonility, HTN STROKE*
Due to (or as a consequence of):c. *CHF*
Due to (or as a consequence of):d. *Alzheimer*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)29b. Signature and title of certifier
Bahram Pishdad
29c. License number
MD 51520
29d. Date signed (Month, Day, Year)
March 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahram Pishdad M.D. 1328 Southern Ave SE Washington, DC #310

31. Date filed (Month, Day, Year)

MAR 13 2000

32. Registrar's Signature

*Beverly B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 20255.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

At a Special Meeting of the Board of Directors
of the [illegible] Company
held at [illegible] on [illegible]

[illegible signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09391

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nevin Lee Warnick						2. Date of Death Month Day Year March 5, 2000		3. Time of Death 2:15 p.m.			
	4a. Facility Name (If not institution, give street and number) Hospice of Baltimore						4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 220-03-7199		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Aug 16, 1918		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 505 Riverside Road				10f. Zip Code 21221		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Drophammer Operator			16b. Kind of Business/Industry Martin-Marietta Corp.				
	17. Father's Name (First, Middle, Last) Olin Warnick						18. Mother's Name (First, Middle, Maiden Surname) Birdie Ruth (Warnick)					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gladys V. Warnick/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Riverside Road, Essex, MD 21221							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grantsville Cem.		20c. Location - City or Town, State March 9, 2000 Grantsville, MD							
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Lymphoma</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 6 years											
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D25205		29d. Date signed (Month, Day, Year) March 5, 2000					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley G-BMC 6701 N. Charles St. Balto. md 21204											
31. Date filed (Month, Day, Year) MAR - 8 2000		32. Registrar's Signature <i>[Signature]</i>										

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09392

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MIRIAM WILLAN

2. Date of Death

Month 3 Day 5 Year 00

3. Time of Death

2:01

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

217-24-7391

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
05/03/1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

505 Congress Ave. Apt 509

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Stirling P. Willan

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Sanders

19a. Informant's Name/Relationship (Type, Print)

David Willan- Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

815 Lafayette St., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Angel Hill Cemetery

Date

3/9/00

20c. Location - City or Town, State

Havre de Grace, MD

21. Signature of Funeral Service Licensee

Dorine M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.
123 S. Washington, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

16 Hrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke

Sarcoidosis

Diabetes Mellitus II

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dorine M. Smith M.D.

29c. License number

D00159984

29d. Date signed (Month, Day, Year)

3-5-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LETICIA S. GALVEZ, M.D. 625 S. UNION AVE. Havre de Grace MD. 21078

31. Date filed (Month, Day, Year)

MAR 7 - 2000

32. Registrar's Signature

A. Sparks

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09393

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAE SUSAN WOLFE

2. Date of Death

Month Day Year
Mar. 05 2000

3. Time of Death

12:55 PM

4a. Facility Name (If not institution, give street and number)

Fahrney-Keedy Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

215-90-1395

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 29, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

60 West Longmeadow Road

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give X
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Roy Wade Grossnickle

18. Mother's Name (First, Middle, Maiden Surname)

Maudie Bell Blickenstaff

19e. Informant's Name/Relationship (Type, Print)

Richard Wolfe/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

217 The Maine, Williamsburg, VA 23185

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Lawn Memorial Park 3/8/2000

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

504 Main Street
Ricketts Funeral Home Myerville, MD 2177323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Pneumonia
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic cardiovascular disease
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
8 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D18017

29d. Date signed (Month, Day, Year)

MARCH 6 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Vasant Datta, M.D., 334 Mill Street, Hagerstown, Maryland 21740

31. Date filed (Month, Day, Year)

MAR 07 2000

32. Registrar's Signature

State
Registrar

Wolfe, Mae S.
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Wolfe, Mae S.
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09394

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mamie Whipp

2. Date of Death

March 2, 2000

3. Time of Death

5:13 P.M.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

217-32-6652

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

September 29, 1911 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6409 Mountaineale Road

10f. Zip Code

21788

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Self

17. Father's Name (First, Middle, Last)

Harry Kauffman

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Kauffman

19a. Informant's Name/Relationship (Type, Print)

Margaret Crouse / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4832 Mt. Zion Rd., Frederick, MD 21703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lewistown Cemetery

Date

03/06/00

20c. Location - City or Town, State

Lewistown, MD

21. Signature of Funeral Service Licensee

D. Douglas Stauffer

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

P.O. Box 1819, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anterior Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Gastrointestinal Bleed

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier

(Check only one)

1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael W. Levangie MD

29c. License number

D47397

29d. Date signed (Month, Day, Year)

3/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael W. Levangie, MD, 310 W. 9th St., Frederick, MD 21701

31. Date filed (Month, Day, Year)

MAR 03 2000

32. Registrar's Signature

Benita P. Spauld

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

PHILLIP

State of Maryland / Department of Health and Mental Hygiene

WEST

AMEND ITEMS: #23 PART I, 27, 28A-F PER MED G781 3-23-2000 WR.

Certificate of Death

Reg. No.

00 09395

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILLIP STERLING WEST				2. Date of Death Month Day Year FEBRUARY 27, 2000		3. Time of Death 5:13P.M.	
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-74-8428	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	8. Date of Birth (Month, Day, Year) NOV. 22, 1959	9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent							
10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 344 EAST 28 TH ST.		10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 TH College (14 or 5+) College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME IMPROVEMENT		16b. Kind of Business/Industry SELF EMPLOY				
17. Father's Name (First, Middle, Last) ALBERT WESR				18. Mother's Name (First, Middle, Maiden Surname) EDNA DENNIS				
19a. Informant's Name/Relationship (Type, Print) BARBARA WEST (SISTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 GLENN ALLEN DR. BALT. MD. 21229				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM.		20c. Date MAR. 4, 2000		20d. Location - City or Town, State BALT. MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FRED. MD. 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NARCOTIC INTOXICATION								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) FOUND: 2-27-1999		28b. Time of Injury FOUND: 4:24		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred UNKNOWN		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: PORCH		28f. Location (Street and Number or Rural Route Number, City or Town, State) 508 E. 28TH ST. BALTIMORE, MARYLAND				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 28, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRISON A. KOBAN 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAR 06 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09396

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THERESA EMMA ZANDER				2. Date of Death Month MARCH Day 10 Year 2000				3. Time of Death 1605		
	4a. Facility Name (If not institution, give street and number) 7845 Lawyers Lane				4b. City, Town, or Location of Death Thurmont				4c. County of Death Frederick		
Funeral Director	5. Social Security Number 199-16-4499		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) June 23, 1925		9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Frederick		10c. City, Town or Location Thurmont		
Usual Residence of Decedent											
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
10e. Street and Number 7845 Lawyers Lane				10f. Zip Code 21788				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Georg Weiskopf				18. Mother's Name (First, Middle, Maiden Surname) Emma Semmet							
19a. Informant's Name/Relationship (Type, Print) Edgar Zander (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7845 Lawyers Lane Thurmont, MD 21788							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory				Date 3/12/00		20c. Location - City or Town, State Smithsburg, MD.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 E. MAIN ST. THURMONT, MD. 21788							
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LIGHT CHAIN DISEASE / MULTIPLE MYELOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Approximate Interval Between Onset and Death 1 YEAR											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATIC BREAST CANCER								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number 031761				29d. Date signed (Month, Day, Year) 3/12/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN M. O'CONNOR MD 581 W. SEVENTH ST. FREDERICK, MD 21701											
31. Date filed (Month, Day, Year) MAR 13 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

4-13-00 WK.

00 09397

AMEND ITEMS: #23 PART I, 27 PER MEO G782

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Charles Arwood, Jr.				2. Date of Death Month Day Year March 18, 2000		3. Time of Death 2109 pm	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-68-8493	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 15, 1955		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1611 Joplin Street				10f. Zip Code 21224		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist			16b. Kind of Business/Industry Chesapeake Machine Co.	
17. Father's Name (First, Middle, Last) David Charles Arwood, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Frances Ellen Parks				
19a. Informant's Name/Relationship (Type, Print) Mr. Wesley L. Arwood (Brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7827 Scholar Road Dundalk, Maryland 21222				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem.		20c. Location - City or Town, State Rossville, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DIABETIC KETOACIDOSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 20, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAR 23 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09398

AMEND#17 PER INFMT G783 5-24-2000 JAB

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARBARA JEAN ASH		2. Date of Death Month Day Year MARCH 16 2000		3. Time of Death 7:11am
	4a. Facility Name (If not institution, give street and number) 94 Berkshire Road		4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 235-38-7020	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day Year) Sept. 18 1925		9. Birthplace (State or Foreign Country) West Virginia		
Usual Residence of Decedent					
10a. State MD		10b. County Baltimore		10c. City, Town or Location Essex	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 94 Berkshire Road			10f. Zip Code 21221		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry own home	
17. Father's Name (First, Middle, Last) ODEWALT John William Olewalt			18. Mother's Name (First, Middle, Maiden Surname) Chole Montgomery		
19a. Informant's Name/Relationship (Type, Print) John W. Ash / husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94 Berkshire Road Baltimore Md. 21221		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc		20c. Location - City or Town, State 3/22/2000 Baltimore MD	
21. Signature of Funeral Service Licensee R. Terry Connelly		22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA Due to (or as a consequence of): ASCVD Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ASCVD Due to (or as a consequence of): ASCVD					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier David J. Seff MD		29c. License number D1008		29d. Date signed (Month, Day, Year) 3/22/00	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) DAVID J. SEFF MD 5 HALCYON COURT BALTO MD					
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature P. Sparks			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 09399

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES ATLAS		2. Date of Death Month MARCH Day 21 Year 2000		3. Time of Death 3:58 PM
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 316-38-2046	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) MAY 14, 1940		9. Birthplace (State or Foreign Country) IN		
Usual Residence of Decedent					
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 3506 SHELBURNE ROAD			10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) C.P.A. & ATTORNEY		16b. Kind of Business/Industry LEGAL
17. Father's Name (First, Middle, Last) HERMAN ATLAS			18. Mother's Name (First, Middle, Maiden Surname) PEARL (UNKNOWN)		
19a. Informant's Name/Relationship (Type, Print) MIRIAM ATLAS / WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3506 SHELBURNE ROAD - BALTIMORE, MD 21208		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) AGUDATH ISRAEL CEMETERY		Date 3/22/00	20c. Location - City or Town, State ROSEDALE, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of):			Approximate Interval Between Onset and Death 1 HOUR
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. CORONARY ARTERY DISEASE Due to (or as a consequence of):			10 YEARS
		c. DIABETES Due to (or as a consequence of):			
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D29391		29d. Date signed (Month, Day, Year) MARCH 21, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENJAMIN VICTOR DUBOIS 1838 GREENE TREE ROAD BALTIMORE, MD 21208					
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature 			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred C. Adams

2. Date of Death

Month Day Year
March 17, 2000

3. Time of Death

6:28pm

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-16-7195

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 23, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

32 Dunvale Rd Apt. 506

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Clarence G. Cline

18. Mother's Name (First, Middle, Maiden Surname)

Emma Gorman

19a. Informant's Name/Relationship (Type, Print)

Edwin W. Adams III / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 35 Monkton, Maryland 21111

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

03/21/00

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Laura C. Hardesty

22. Name and Address of Facility

CAFA- Stephen D. Lohrmann PA
8717 Green Pastures Dr Balto., MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pulmonary hypertension

Due to (or as a consequence of):

b.

Chronic obstructive pulmonary disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 weeks

15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DUNN T WEGLEIN MD

29c. License number

D26394

29d. Date signed (Month, Day, Year)

3/19/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUNN T WEGLEIN, MD.

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

B. Sparks

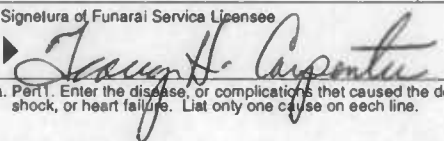
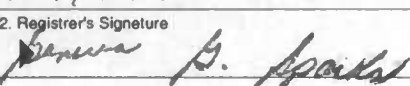
State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09401

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eugene N. Bigham				2. Date of Death Month Day Year MARCH 20th 2000		3. Time of Death 11:35 PM	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-07-3807		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 14, 1918	
	Usual Residence of Decedent		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 5910 Marluth Avenue		10f. Zip Code 21206		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Asbestos Worker Local 11		16b. Kind of Business/Industry Industrial Asbestos Work				
17. Father's Name (First, Middle, Last) Edward Bigham				18. Mother's Name (First, Middle, Maiden Surname) Alice Mann				
19a. Informant's Name/Relationship (Type, Print) Emma Bigham Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5910 Marluth Avenue, Baltimore, Maryland 21206				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		20c. Location - City or Town, State 3/24/2000 Fullerton, Maryland				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATRIAL FIBRILLATION Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 20 DAYS 20 DAYS						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier George Hennawi, MD				29c. License number AT2438946		29d. Date signed (Month, Day, Year) MARCH 21st 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Hennawi, MD UMH.								
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature 						

ORIGINAL

Chrysomelid

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09403

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard J. Black, Sr.				2. Date of Death Month Day Year 03/20/00		3. Time of Death 9:15PM	
	4a. Facility Name (If not institution, give street and number) 3202 Moravia Road				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-54-1269		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) 01/27/1950	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3202 Moravia Road		10f. Zip Code 21214		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1969-71		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Restaurant Owner		16b. Kind of Business/Industry Self-employed		17. Father's Name (First, Middle, Last) Harry J. Black	
	18. Mother's Name (First, Middle, Maiden Surname) Margaret M. Warns		19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Suzanne Black - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3202 Moravia Road, Baltimore, Maryland 21214		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		20c. Date 03/24/00		20d. Location - City or Town, State Baltimore, Maryland		21. Signature of Funeral Service Licensee Christina L. David	
	22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Malignant Glioma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2 1/2 yrs		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier Shalini Kamal MBBS		29c. License number D0039788		29d. Date signed (Month, Day, Year) 3/22/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shalini Kamal, 9512 N. Harford Rd. Balt MD. 21234	
State Registrar	31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature S. Sparks		33. Date of Death 03/20/00		34. Time of Death 9:15PM	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09404

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joel Bolado				2. Date of Death Month Day Year MARCH 19, 2000		3. Time of Death 10:55AM	
	4a. Facility Name (If not institution, give street and number) VA MARYLAND HEALTH CARE SYSTEM				4b. City, Town, or Location of Death PERRY POINT		4c. County of Death CECIL	
Funeral Director	5. Social Security Number 221-30-3862	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 14, 1947		9. Birthplace (State or Foreign Country) Texas
	Usual Residence of Decedent							
10a. State MD		10b. County Cecil		10c. City, Town or Location Rising Sun			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 346 Barnes Corner Rd.				10f. Zip Code 21911		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Mexican American			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker			18b. Kind of Business/Industry Factory	
17. Father's Name (First, Middle, Last) Rueben Dario Bolado				18. Mother's Name (First, Middle, Maiden Surname) Pauleen Koker				
19a. Informant's Name/Relationship (Type, Print) James H. Bolado/ son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 346 Barnes Corner Rd, Rising Sun, MD 21911				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 03/21/00		20c. Location - City or Town, State Beltsville, MD
21. Signature of Funeral Service Licensee <i>Laura C. Hardesty</i>				22. Name and Address of Facility CAFA-Stephen D. Lohrmann PA 8717 Green Pastures Dr. Balto., MD 21286				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ESOPHAGEAL CANCER Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 4 MONTHS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Fadi Damouni</i>		29c. License number C10005379		29d. Date signed (Month, Day, Year) March 19, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FADI DAMOUNI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902								
31. Date filed (Month, Day, Year) MAR 23 2000				32. Registrar's Signature <i>B. Sparks</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME KNOWN TO PHYSICIAN: BOLADO, JOEL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

James Madison Bungori

2. Date of Death

March 15, 2000 Year

3. Time of Death

10:55 P.M.

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

212-88-1321

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 31, 1968 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

324 Superior St.

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1985-1986

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Adecco Employment Services

17. Father's Name (First, Middle, Last)

Joseph Bungori Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Eileen M. Ross

19a. Informant's Name/Relationship (Type, Print)

Joseph Bungori Jr. / father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

558 Meadowood Dr. Edgewood, MD 21040

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, INC

Date

03/20/00

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Laura C. Hardesty

22. Name and Address of Facility

CAFA- Stephen D. Lohrmann PA
8717 Green Pastures Dr. Balto., MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

NARCOTIC AND ALCOHOL INTOXICATION

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☒ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

3-15-2000

28b. Time of Injury

UNKNOWN M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State)

UNKNOWN

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. L. Lofgren, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. L. Lofgren, MD 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

J. L. Lofgren, MD

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09406

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lawrence M. Chester, Sr.</i>				2. Date of Death Month Day Year <i>March 21 2000</i>		3. Time of Death <i>6:00pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>3108 Acton Rd.</i>				4b. City, Town, or Location of Death <i>Parkville</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>219-30-0408</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>65</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Aug. 1, 1934</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Md</i>	10b. County <i>Baltimore</i>	10c. City, Town or Location <i>Parkville</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>3108 Acton Rd.</i>			10f. Zip Code <i>21234</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>building inspector</i>		16b. Kind of Business/Industry <i>Baltimore City</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Roy Chester</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Thelma L. Mitchell</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Don Ann Chester spouse</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3108 Acton Rd. Baltimore, Md. 21234</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Evans Funeral Chapel-Bel Air</i>		20c. Location - City or Town, State <i>March 2000 Forest Hill, Maryland</i>		20d. Location (Street and Number or Rural Route Number, City or Town, State)	
	21. Signature of Funeral Service Licensee <i>Heidi S. Wells</i>		22. Name and Address of Facility <i>Evans Funeral Chapel 8800 Harford Rd. Baltimore, Maryland 21234</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> a. <i>CARDIAC ARRHYTHMIA</i> Due to (or as a consequence of): b. <i>CHRONIC RENAL FAILURE</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ </div> <div style="width: 60%;"> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>D. Powell, MD</i>								
29c. License number <i>D0045507</i>								
29d. Date signed (Month, Day, Year) <i>3/23/2000</i>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Daniel Picard 9000 Franklin Square Dr. Rosedale, Maryland</i>								
31. Date filed (Month, Day, Year) <i>MAR 23 2000</i>								
32. Registrar's Signature <i>Benita B. Sparks</i>								

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09407

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James E. L. Connolly, Jr.				2. Date of Death Month MARCH Day 20 Year 2000		3. Time of Death 2212 PM
	4a. Facility Name (If not institution, give street and number) 2124 ASHTON STREET				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A
Funeral Director	5. Social Security Number 212-42-1295	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 10, 1943	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2124 Ashton Street			10f. Zip Code 21223		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Self Employed		
	17. Father's Name (First, Middle, Last) James E. L. Connolly, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Unknown			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) James Connolly, III Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3637 Elm Avenue, Baltimore, Maryland 21211			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory Baltimore-Washington		20c. Location - City or Town, State Laurel, Maryland		20d. Date 2/27/2000
	21. Signature of Funeral Service Licensee Lynn B. Henss			22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Liver failure Due to (or as a consequence of): b. Cirrhosis Due to (or as a consequence of): c. Alcoholism Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Chronic obstructive pulmonary disease						
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? Limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Stephen S. Radentz			29c. License number OCME		29d. Date signed (Month, Day, Year) MARCH 21, 2000		
30. Name and address of person who completed cause of death (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

08-09408

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH E. CHAPMAN				2. Date of Death Month Day Year MARCH 17, 2000		3. Time of Death 7:45pm				
	4a. Facility Name (If not institution, give street and number) BON SECOUR HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A				
Funeral Director	5. Social Security Number 214-12-4385		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) 1-21-1921		9. Birthplace (State or Foreign Country) MD.		
	10a. State MD.				10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Funeral Director		10e. Street end Number 3600 W. FRANKLIN ST. APT 5P				10f. Zip Code 21229		10g. Citizen of What Country? USA			
		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) -12- -0-		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CASE WORKER		16b. Kind of Business/Industry STATE					
		17. Father's Name (First, Middle, Last) CHARLES CHAPMAN		18. Mother's Name (First, Middle, Maiden Surname) GEORGIA BROWN							
		19a. Informant's Name/Relationship (Type, Print) MARY BAILEY (FRIEND)				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2015 WHITTIER AVE. BALTIMORE, MARYLAND 21217					
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) ENTOMBMENT		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK		20c. Location - City or Town, State BALTIMORE, MARYLAND					
		21. Signature of Funeral Service Licensee Vernon R. Bailey				22. Name and Address of Facility VERNON R. BAILEY FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Septic Shock Due to (or as a consequence of): b. Carcinoma Vulva Metastatic Due to (or as a consequence of): c. 5 Liver d. Approximate Interval Between Onset and Death 1 day 4 months									
Physician /Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier M. R. L.		29c. License number D25044		29d. Date signed (Month, Day, Year) 3/27/00			
State Registrar		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M. R. L.				2000 W. BALTIMORE ST. BALTIMORE, MARYLAND 21223					
		31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature Geneva B. Sparks							

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State of Maryland / Department of Health and Mental Hygiene 00 09409

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES DORSEY

2. Date of Death

Month Day Year
3 20 2000

3. Time of Death

10:35 a.m.

4a. Facility Name (If not institution, give street and number)

Genesis Elder Care

4b. City, Town, or Location of Death

Towson

4c. County of Death

Balto

Funeral
Director

5. Social Security Number

149-09-0109

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
5-17-1918

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3808 Copley Road

10f. Zip Code

21215

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

Master Degree

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Baltimore City Public Schools

17. Father's Name (First, Middle, Last)

Oakford Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Nona Stevens

19a. Informant's Name/Relationship (Type, Print)

Irwin Dorsey - Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

313 E. Coldspring Lane Baltimore, Md

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veteran

Date

3-27-00

20c. Location - City or Town, State

Owings Mills, Md

21. Signature of Funeral Service Licensee

Shannon Stokes

22. Name and Address of Facility

March F/H West

4300 wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *CHF*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *ASCVD*
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ABD, HTN, paroxysmal Afib Hypertension
Depression Enalapril

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Muraymundo MD

29c. License number

054518

29d. Date signed (Month, Day, Year)

3/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3007 Northern Parkway Baltimore MD 21214

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

Benjamin B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09410

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lucy R. Davis				2. Date of Death Month March Day 12 Year 2000				3. Time of Death 4:05PM		
	4a. Facility Name (If not institution, give street and number) Mariner Health Of North Arundel				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 215-10-7629		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) January 7, 1904		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10a. State Maryland				10b. County Anne Arundel		10c. City, Town or Location Glen Burnie
To Be Completed by Funeral Director		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 509 Stewart Avenue, S.W.				10f. Zip Code 21061	
		10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Store Manager				16b. Kind of Business/Industry Sales				17. Father's Name (First, Middle, Last) John Baldwin	
To Be Completed by Physician/Medical Examiner		18. Mother's Name (First, Middle, Maiden Surname) Roberta G. Fields				19a. Informant's Name/Relationship (Type, Print) Carvey G. Davis-Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Stewart Avenue, S.W., Glen Burnie, Maryland 21061	
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery				20c. Location - City or Town, State 3-16-00 Baltimore, Maryland	
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <i>Lisa L. Johnson</i>				22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, Maryland 21229				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. urosepsis Due to (or as a consequence of): b. dehydration Due to (or as a consequence of): c. dementia Due to (or as a consequence of): d.	
		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure, atrial fibrillation, hypertension, diabetes, coronary artery disease				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 1241955	
To Be Completed by Physician/Medical Examiner		29d. Date signed (Month, Day, Year) 3-15-00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Becca Elan MD 479 Jumpers Hole Rd Severna Park MD 21146				31. Date filed (Month, Day, Year) MAR 22 2000	
		32. Registrar's Signature <i>[Signature]</i>				33. Registrar's Title B. Sparks				34. Registrar's Office Severna Park MD 21146	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#4B PER MD.& 10e PER F.H. G781 3-23-2000 TAB

Certificate of Death

Reg. No.

00 09411

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AGGIE NORA DUDLEY				2. Date of Death Month Day Year 03 17 2000		3. Time of Death 13:00	
	4a. Facility Name (If not institution, give street and number) 3823 Cherrybrook Road				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 108-26-0306		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) 07 11 05	
	9. Birthplace (State or Foreign Country) N.C.		10a. State MD		10b. County Baltimore Co.		10c. City, Town or Location Randallstown	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3823 CHERRYBROOK Road		10f. Zip Code 21133		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) James Hardy		
18. Mother's Name (First, Middle, Maiden Surname) Mary Hardy		19a. Informant's Name/Relationship (Type, Print) Sandra M. Cooper-Great Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3823 Cherrybrook Road, Randallstown, Md 21133		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State 3-23-00 Baltimore, Md		21. Signature of Funeral Service Licensee John March		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSION Due to (or as a consequence of): b. DEPRESSION Due to (or as a consequence of): c. WEIGHT LOSS Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Glynis A Moody, MD		
29c. License number 050233		29d. Date signed (Month, Day, Year) 3/20/2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLYNIS A MOODY, MD 1000 CATHEDRAL STREET BALTIMORE, MD 21207		31. Date filed (Month, Day, Year) MAR 23 2000		
32. Registrar's Signature B. Sparks		State Registrar		33. Date of Death 03 17 2000		34. Time of Death 13:00		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09412

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nora T. Dyson				2. Date of Death Month: 3 Day: 20 Year: 2000		3. Time of Death 8:05 a.m.	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-40-2317		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min:	8. Date of Birth (Month, Day, Year) 3-24-1938	
	9. Birthplace (State or Foreign Country) D.C.							
Usual Residence of Decedent								
10a. State Md		10b. County Harford		10c. City, Town or Location Belcamp			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 4215 Chapel Gate Drive				10f. Zip Code 21017		10g. Citizen of What Country? U S A		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 8th grade College (1-4 or 5+): N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook			16b. Kind of Business/Industry Catholic Church	
17. Father's Name (First, Middle, Last) Unk				18. Mother's Name (First, Middle, Maiden Surname) Margaret Gant				
19a. Informant's Name/Relationship (Type, Print) Rose Michelle Wooden-Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4215 Chapel Gate Drive Belcamp, Md 21017				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery		20c. Location - City or Town, State Laplata, Md		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 2 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D25205		29d. Date signed (Month, Day, Year) March 20, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GMC 16701 N. Charles St. Balto. Md 21205								
31. Date filed (Month, Day, Year) MAR 23 2000				32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09413

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Blanche Durika				2. Date of Death Month Day Year March 20 2000				3. Time of Death 0957	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 215-32-0166		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Dec. 16, 1934		9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 365 Nicholson Road		10f. Zip Code 21221		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (1-4 or 5+) College		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Frank Tester		18. Mother's Name (First, Middle, Maiden Surname) Not Known		19a. Informant's Name/Relationship (Type, Print) Marquitta M. Huff (Daughter)		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 North Marlyn Ave. Essex, Maryland 21222		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cem.		20c. Location - City or Town, State 3/23/2000 Dundalk, Maryland		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VANCOMYCIN RESISTANT ENTEROCOCCAL ENDocardITIS		Approximate Interval Between Onset and Death 18 days		Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Matthew Hernandez M.D.		29c. License number P11614		
29d. Date signed (Month, Day, Year) March 20, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATHEW HERNANDEZ UNIVERSITY OF MARYLAND DEPARTMENT OF MEDICINE BALTIMORE, MARYLAND 21210		31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature 		State Registrar		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09414

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Dorsett				2. Date of Death Month Day Year March 17, 2000		3. Time of Death 8:35pm	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 216-96-7202		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 34 Yrs.		8. Date of Birth (Month, Day, Year) March 24, 1965	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Essex	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 25 Palczar Rd.		10f. Zip Code 21221		10g. Citizen of What Country? United States		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter		16b. Kind of Business/Industry Baynes Painting				
17. Father's Name (First, Middle, Last) Richard W. Dorsett				18. Mother's Name (First, Middle, Maiden Surname) JoAnn Lewis				
19a. Informant's Name/Relationship (Type, Print) Charles Stacey Dorsett/ Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Palczar Rd. Essex, MD 21221				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory Inc.		20c. Date 3/20/00		20d. Location - City or Town, State Beltsville, MD		
21. Signature of Funeral Service Licensee Laura C. Hardesty				22. Name and Address of Facility CAFA-Stephen D. Lohrmann P.A. 8717 Green Pastors Dr. Baltimore, MD 21286				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Subdural Hematoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dr. Chou, Resident Physician				29c. License number RES-000		29d. Date signed (Month, Day, Year) March 17, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dean Chou, 600 North Wolfe Street, Baltimore, Maryland								
31. Date filed (Month, Day, Year) MAR 23 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09415

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DIANA H. ELMORE				2. Date of Death Month Day Year March 21 2000		3. Time of Death 7:10 a.m.	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 216-32-9314		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1-10-1937	9. Birthplace (State or Foreign Country) Md
	Usual Residence of Decedent							
10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 334 S. Augusta Avenue				10f. Zip Code 21229		10g. Citizen of What Country? U S A		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 2years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Clerk		16b. Kind of Business/Industry Kronheim Company Inc		
17. Father's Name (First, Middle, Last) Curtis Hurtt				18. Mother's Name (First, Middle, Maiden Surname) Zelma Curry				
19a. Informant's Name/Relationship (Type, Print) Michael Elmore - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 334 S. Augusta Avenue Baltimore, Md 21229				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery 3-25-00 Baltimore, Md		Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								a. Metastatic Carcinoma of Lung to Brain 1 yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								b. Lung Carcinoma 3-4 yrs
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD Resident		29c. License number P13599		29d. Date signed (Month, Day, Year) March 21 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Steppie 700 caton AVE 2 1044 Baltimore MD								
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

Certificate of Death

Reg. No. 00 09416

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM A EVERING				2. Date of Death Month Day Year March 22, 2000		3. Time of Death 8:30 AM			
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 206-36-9823		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) April 18 1946		9. Birthplace (State or Foreign Country) Texas	
	Usual Residence of Decedent									
10a. State MD		10b. County Baltimore		10c. City, Town or Location Middle River				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 438 Grovethorn Road				10f. Zip Code 21220		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) lyr				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer			16b. Kind of Business/Industry Test Point			
17. Father's Name (First, Middle, Last) Louis E. Evering					18. Mother's Name (First, Middle, Maiden Surname) Jacqueline M Gremler					
19a. Informant's Name/Relationship (Type, Print) Nancy Evering / wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 438 Grovethorn Road Baltimore MD 21220					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery			Date 3/25/2000		20c. Location - City or Town, State Baltimore Md.		
21. Signature of Funeral Service Licensee R. Terry Connelly					22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Squamous Cell Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1-2 years										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier [Signature], MD					29c. License number RD 1988 79		29d. Date signed (Month, Day, Year) March 22, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kauser Khan 9000 Franklin Square Drive Baltimore, MD. 21237										
31. Date filed (Month, Day, Year) MAR 23 2000					32. Registrar's Signature [Signature]					

ORIGINAL

3/23/00
Amended Item 20a, 20b, 20c, 21, 22
per FH, Item 29 dper DR, G781dhh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09417

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS EVANS

2. Date of Death

Month Day Year
JANUARY 18, 2000

3. Time of Death

1437

4a. Facility Name (If not institution, give street and number)

BON SECOURS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral
Director

5. Social Security Number

220-18-8127

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
8/16/1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

942 Brooks Lane

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

2 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health

17. Father's Name (First, Middle, Last)

George Wheeler

18. Mother's Name (First, Middle, Maiden Surname)

Ada Cornish

19a. Informant's Name/Relationship (Type, Print)

Theodore Wheeler/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1948 W. North Avenue, Balto., Md 21217

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

1/31/00

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Laura C. Hardesty, per DVR

22. Name and Address of Facility

CAFA Stephen D. Lohrmann, P.S., 8717
Green Pastures Dr., Balto., MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTEROSCLEROTIC CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40089

29d. Date signed (Month, Day, Year)

March 15, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RHAINI LIGONI 2000 W. BALTIMORE STREET BALTIMORE, 21223

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09418

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harold E. Futch

2. Date of Death

Month

Day

Year

March 22 2000

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-16-9852

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 25, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Reezy Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3800 Meghan Dr. #2C

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Quality Controlman

16b. Kind of Business/Industry

Western Electric

17. Father's Name (First, Middle, Last)

Stoy Futch

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Henck

19a. Informant's Name/Relationship (Type, Print)

Doris C. Futch

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

spouse 3800 Meghan Dr #2C Baltimore Md 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Mem. Gdns

Date

March 25 2000

20c. Location - City or Town, State

Timonium Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd Baltimore, Md 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 Week

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Staph Aureus Infection

Due to (or as a consequence of):

1 Week

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

RD 189142

29d. Date signed (Month, Day, Year)

March 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Weien Agate 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

[Signature]

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

3/23/00
Amended Item 25, 26 per DR G781, dhh

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09419

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OLIVE E. FINNEY						2. Date of Death Month Day Year March 9 2000		3. Time of Death 8:05PM																					
	4a. Facility Name (If not institution, give street and number) 3043 Second Avenue						4b. City, Town, or Location of Death Baltimore County		4c. County of Death Baltimore																					
Funeral Director	5. Social Security Number 218-16-1316		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 11, 1922		9. Birthplace (State or Foreign Country) Ireland																					
	Usual Residence of Decedent																													
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore County				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
10e. Street and Number 3043 Second Avenue				10f. Zip Code 21234		10g. Citizen of What Country? USA																								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE																						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse			16b. Kind of Business/Industry State of Maryland																							
17. Father's Name (First, Middle, Last) Richard Elliott						18. Mother's Name (First, Middle, Maiden Surname) Ada Hurley																								
19a. Informant's Name/Relationship (Type, Print) Jody Marks						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 201 Fawn Grove, PA 17321																								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc March 11, 2000		20c. Location - City or Town, State Baltimore, Maryland																								
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility LASSAHN FUNERAL HOME 7401 Belair Rd. Baltimore, Md. 21236																								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																														
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Respiratory Failure</td> <td>- 1 week</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Carcinoma of the lung</td> <td>- 1 week</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="3"></td> </tr> <tr> <td>d.</td> <td colspan="3"></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Respiratory Failure	- 1 week	Due to (or as a consequence of):			b.	Carcinoma of the lung	- 1 week	Due to (or as a consequence of):			c.				d.			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Respiratory Failure	- 1 week																											
	Due to (or as a consequence of):																													
	b.	Carcinoma of the lung	- 1 week																											
	Due to (or as a consequence of):																													
c.																														
d.																														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Fibrosis																														
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown																														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																														
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> POA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred																						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																								
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																														
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D21846		29d. Date signed (Month, Day, Year) 3/10/00																								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN J. Sheridan, M.D. 6830 Hospital Drive BALTO. MD 21237																														
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature <i>[Signature]</i>																												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09420

Forchheimer, Trude.
 Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) TRUDE FORCHHEIMER		2. Date of Death Month Day Year MARCH 20 2000		3. Time of Death 12:45 pm	
4a. Facility Name (If not institution, give street and number) SINAI Hospital of Baltimore		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
5. Social Security Number 212-10-6654	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) DEC. 23, 1913
8. Birthplace (State or Foreign Country) FRANCE		9. Birthplace (State or Foreign Country) FRANCE			
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE			
10e. Street and Number 6318 GREENSPRING AVENUE #107		10f. Zip Code 21209		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) College			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ANTIQUE DEALER		16b. Kind of Business/Industry ANTIQUE			
17. Father's Name (First, Middle, Last) SIGMUND VOLLWEILER		18. Mother's Name (First, Middle, Maiden Surname) JOHANNA OPPENHEIM			
19a. Informant's Name/Relationship (Type, Print) JAY S. LEWIS / NEPHEW		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 BEEHIVE PLACE #K - COCKEYSVILLE, MD 21030			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHEVRA AHAVAS CHESD		20c. Location - City or Town, State 3/22/00 RANDALLSTOWN, MD	
21. Signature of Funeral Service Licensee <i>Jay S. Lewis</i>		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL Fibrillation Congestive Heart Failure Uremia.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury 1 Yes <input type="checkbox"/> No <input type="checkbox"/> No 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <i>Snedden</i> Physician		29c. License number DO054558	
29d. Date signed (Month, Day, Year) MARCH 20, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK BURKE 2401 W. Belvedere Baltimore, MD 21215.			
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature <i>B. Sparks</i>	

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09421

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Andrew

Gilroy

2. Date of Death

March 16

2000

3. Time of Death

18:43

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

Baltimore City

4b. City, Town, or Location of Death

4c. County of Death

Funeral
Director

5. Social Security Number

213 68 2925

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

40

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

August 1, 1959

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

HARFORD

10c. City, Town or Location

EDGEWOOD

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

645 Longwood Court

10f. Zip Code

21040

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SURVEYOR

16b. Kind of Business/Industry

T.C. SIMONS, INC.

17. Father's Name (First, Middle, Last)

PAUL S. GILROY, SR.

18. Mother's Name (First, Middle, Maiden Surname)

VALLIE JANE KELLER

19a. Informant's Name/Relationship (Type, Print)

MARGARET GILROY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

392 ELLSWORTH PLACE APT A2 JOPPA, MARYLAND 21085

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL - BELAIR, P.A.

Date

MARCH 18, 2000

20c. Location - City or Town, State

FOREST HILL MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS FUNERAL CHAPEL - BELAIR, P.A. 21085
30 NEWPORT DRIVE FOREST HILL MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hepatic Failure

Due to (or as a consequence of):

2 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide ☐ Could not be determined
☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. L. JUNG MEDICAL DOCTOR

29c. License number

Res - 000

29d. Date signed (Month, Day, Year)

March 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julianna Jung 600 North Wolfe Street Baltimore Maryland 21201

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09422

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

LUCILLE GIBSON

2. Date of Death

MARCH

Day

19

Year

2000

3. Time of Death

1:35 PM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALITMORE

4c. County of Death

N/A

5. Social Security Number

219-28-2414

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 6, 1919

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

131 W. Edgevale Road

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Raleigh
Manufacturing Company

17. Father's Name (First, Middle, Last)

Henry Moore

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Glanice Belen (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

131 W. Edgevale Road Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

3/22/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Christina A. Nitter

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACUTE RESPIRATORY DISTRESS SYNDROME ONE WEEK

Due to (or as a consequence of):

b. URINARY TRACT INFECTION

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

RESIDENT PHYSICIAN

29c. License number

P11949

29d. Date signed (Month, Day, Year)

MARCH 19 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABHAY MOGHEKAR, HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST., BALTIMORE, MD

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
800-368-5800.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09423

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Gilmore, Sr.				2. Date of Death Month March Day 19 Year 2000		3. Time of Death 1:35 P.M.		
	4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 151-28-6856		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 15, 1934		
	9. Birthplace (State or Foreign Country) SOUTH CAROLINA		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2021 W. BALTIMORE ST.		10f. Zip Code 21223		10g. Citizen of What Country? USA.		
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) 8TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LANDSCAPER		16b. Kind of Business/Industry LANDSCAPING CO.				
	17. Father's Name (First, Middle, Last) JAMES GILMORE		18. Mother's Name (First, Middle, Maiden Surname) THELMA (MN - UNKNOWN)		19a. Informant's Name/Relationship (Type, Print) ANNIE GRAVES (WIFE)				
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2021 W. BALTIMORE ST. BALTO, MD. 21223		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK 03-24-00 WOODLAWN, MARYLAND		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217						
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Severe peripheral vascular disease Due to (or as a consequence of): b. Severe ischemic cardiomyopathy Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute & chronic Renal Failure							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier , Medical House Officer		29c. License number D0045148		29d. Date signed (Month, Day, Year) March, 19, 2000		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICARDO OSORNO M.D. 2000 W. BALTIMORE STREET, 21223							31. Data filed (Month, Day, Year) MAR 23 2000	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature 		33. Registrar's Name B. Sparks						
	34. State Registrar State Registrar		35. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09424

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Garrett

2. Date of Death

March 21 2000

3. Time of Death

2024

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-14-3133

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 16, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6542 Parnell Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (14 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lewis Piskor

18. Mother's Name (First, Middle, Maiden Surname)

Augusta Miller

19a. Informant's Name/Relationship (Type, Print)

Mr. Ronald Garrett (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6542 Parnell Ave. Baltimore, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

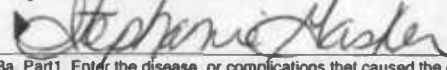
cemetery, crematory or other place)

Sacred Ht. of Jesus Cem. 3/25/2000 Dundalk, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. asystolic cardiac arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. coronary artery disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

hypertension, diabetes, chronic renal failure, congestive heart failure, cerebral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined7 ☐ Could not be determined8 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. Eubank M.D.

29c. License number

97015

29d. Date signed (Month, Day, Year)

March 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Eubank M.D. Johns Hopkins Bayview Medical Center, Baltimore

State
Registrar

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09425

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wilmer C. Glaser Jr.

2. Date of Death
Month Day Year
MARCH 22, 20003. Time of Death
11:20 AM

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-24-7622

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Montha Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11/11/28

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Carney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9529 Fuller Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Cement Contractor

16b. Kind of Business/Industry

Home Improvement
Residential

17. Father's Name (First, Middle, Last)

Wilmer C. Glaser Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Viola Waitz

19a. Informant's Name/Relationship (Type, Print)

Karen Fouche' / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

616 Lee Pl. Frederick, Maryland 21702

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenmount Crematory

Date

3/27/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

David J. Weber Funeral Homes, P.A.

5311 Edmondson Avenue Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC RENAL CELL CANCER

Due to (or as a consequence of):

9 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS with AORTIC VALVE REPLACEMENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Aurora C. Tan, M.D.

29c. License number

D 14958

29d. Date signed (Month, Day, Year)

March 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AURORA C. TAN, MD. 9600 NORTH POINT ROAD, FORT HOWARD, MD. 21052

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

AKA: WILMER C. GLASER
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2025.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09426

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Effie Hall

2. Date of Death
Month Day Year
February 23, 2000
3. Time of Death
5:15 PM

4a. Facility Name (If not institution, give street and number)

2150 1/2 Lake Drive

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

198-30-6105

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 30, 1938

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

2150 1/2 Lake Drive

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

1 year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Board of Education

17. Father's Name (First, Middle, Last)

Lloyd Yerger

18. Mother's Name (First, Middle, Maiden Surname)

Effie Ninkovich

19a. Informant's Name/Relationship (Type, Print)

Archie Hall Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2150 1/2 Lake Drive Pasadena MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Feb. 26, 2000 Fredericksburg PA

21. Signature of Funeral Service Licensee

Christina A. Nitton

22. Name and Address of Facility

McCully-Polyniak Funeral Home, PA
3204 Mountain Rd. Pasadena MD 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. MI

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Signature

29c. License number

D41698

29d. Date signed (Month, Day, Year)

03/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen C. Hamilton, MD 295 Radow Ave Annapolis

State
Registrar

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09427

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wanda Higgs				2. Date of Death Month Day Year March 22, 2000		3. Time of Death 8:00 AM	
	4a. Facility Name (If not institution, give street and number) 1201 Tennant Way				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 578-34-6245		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) April 6, 1926	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1201 Tennant Way		10f. Zip Code 21224		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled		16b. Kind of Business/Industry Disabled		17. Father's Name (First, Middle, Last) Martin H. Mallory	
	18. Mother's Name (First, Middle, Maiden Surname) Nora Elizabeth Allen		19a. Informant's Name/Relationship (Type, Print) Virginia Mallory Sister-in-law		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 261 Severn Road, Millersville, Maryland 21108		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory Baltimore-Washington		20c. Location - City or Town, State Laurel, Maryland		21. Signature of Funeral Service Licensee Lynn B. Henss		22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. diabetes Mellitus Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 1 year		Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
State Registrar	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier J. van Edmond MD		29c. License number P11339		29d. Date signed (Month, Day, Year) March 23, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Ave. Balt. MD 21224	
AH	31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature B. Sparks		33. Date of Death (Month, Day, Year) March 22, 2000		34. Time of Death 8:00 AM	

ORIGINAL

James B. H. H.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09428

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOIS ELIZABETH HENTHORN

2. Date of Death

Month Day Year
March 18 2000

3. Time of Death

0905

4a. Facility Name (If not institution, give street and number)

52 FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

216-24-5895

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 29, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

500 Ramblewood Drive Apt. 106

10f. Zip Code

21009

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William

F.

Kirwan

18. Mother's Name (First, Middle, Maiden Surname)

Margaret

May

Meginnis

19a. Informant's Name/Relationship (Type, Print)

Richard Henthorn (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

500 Ramblewood Drive Apt 106 Abingdon, Md 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Pk. 3/22/00

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aortic MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

HYPERCHOLESTEROLEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

DME

29c. License number

DCME

29d. Date signed (Month, Day, Year)

MARCH 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GSPRABHU MD 728 BELAIR MD BELAIR MD 21014 410-879-6564

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Henthorn, Lois

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09429

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Helen Hofmann					2. Date of Death Month Day Year March 22, 2000		3. Time of Death 9:10 A.M.		
	4a. Facility Name (If not institution, give street and number) Blakehurst Retirement Community					4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore Co.		
Funeral Director	5. Social Security Number 217-48-2274		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) January 27, 1914		9. Birthplace (State or Foreign Country) Baltimore, Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 1055 West Joppa Road Apt.#630					10f. Zip Code 21204		10g. Citizen of What Country? United States of America			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) John Gill Murphy					18. Mother's Name (First, Middle, Maiden Surname) Margaret Elizabeth Kelly					
19a. Informant's Name/Relationship (Type, Print) Mr. Andrew G. Hofmann(Son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25892 Jamon Lane Mission Viejo, California, 92691					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		Date 3/25/2000		20c. Location - City or Town, State Timonium, Maryland			
21. Signature of Funeral Service Licensee Jeffrey L. Gair					22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>Congestive heart failure</u> 10 years Due to (or as a consequence of): b. <u>Myocardial infarction</u> 10 years Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary artery disease</u>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 29c. License number D32783					29d. Date signed (Month, Day, Year) 3/22/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Adams, M.D. 6565 North Charles Street Suite 605 Baltimore, Md. 21204										
31. Date filed (Month, Day, Year) MAR 23 2000			32. Registrar's Signature B. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09430

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Judy Elaine Hopson

2. Date of Death

March 19

2000

3. Time of Death

10:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

216-54-4748

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day, Year)

May 4, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

905 Wampler Road

10f. Zip Code

21220

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Construction Co.

17. Father's Name (First, Middle, Last)

Arthur Hopson

18. Mother's Name (First, Middle, Maiden Surname)

Shirley Elaine Johnson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elaine Hopson (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

901 Wampler Road Baltimore, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gdns. 3/23/2000

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

Chad M. Luby

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Subarachnoid Hemorrhage

Approximate Interval Between Onset and Death

24 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Mary Beth Anderson

29c. License number

KD 199190

29d. Date signed (Month, Day, Year)

March 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Mary Beth Anderson 9000 Franklin Square Drive Baltimore, Maryland 21237

State
Registrar

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

B. Sparks

Hopson, Judy
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09431

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN HENRY HOLMES JR.

2. Date of Death

March 20, 2000

3. Time of Death

0310

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-20-9163

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 31, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2308 OSWEGO AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11th GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

POSTAL CLERK

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

JOHN HENRY HOLMES SR.

18. Mother's Name (First, Middle, Maiden Surname)

ALICE WHITE

19a. Informant's Name/Relationship (Type, Print)

MILDRED HOLMES (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2308 OSWEGO AVENUE, BALTIMORE, MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

DULANEY VALLEY

Date

03-24-00 TIMONIUM, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTO. MD. 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Coronary Heart Disease

Due to (or as a consequence of):

b. Aortic Valve Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Sudden

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 15533

29d. Date signed (Month, Day, Year)

3/21/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRYSOLOGUE GAKUBA, 2 Reservoir Circle, SLEIGHS, MD 21208

State
Registrar

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09432

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK HORACEK				2. Date of Death Month Day Year MARCH 21, 2000		3. Time of Death 9:40 A.M.	
	4e. Facility Name (If not institution, give street and number) HOLLY HILL MANOR NURSING HOME				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-05-1935		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) 6/29/04	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County N/A	
To Be Completed by Funeral Director	10c. City, Town or Location BALTIMORE CITY				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1327 CROFTON ROAD	
	10f. Zip Code 21239				10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 YEARS				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CABINET MAKER		16b. Kind of Business/Industry BGE	
	17. Father's Name (First, Middle, Last) FRANK HORACEK, SR.				18. Mother's Name (First, Middle, Maiden Surname) ANASTASIA KOZLOVSKY			
	19e. Informant's Name/Relationship (Type, Print) MARIE C. MAEVERS DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4615 PROSPECT AVE. GLYDON, MD 21071			
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC.		20c. Location - City or Town, State 3/22/2000 CATONSVILLE, MD	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Arteriosclerosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____				Approximate Interval Between Onset and Death Yearly			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier				29c. License number D-17041		29d. Date signed (Month, Day, Year) 21 MARCH 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARC I. LEAVEY, MD 1205 York Road Suite 38 Lutherville MD 21093								
31. Date filed (Month, Day, Year) MAR 23 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09433

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

June E. Jacobs

2. Date of Death

March 20 2000 0115

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

217-34-9065

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 22, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Street

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4325 Madonna Rd

10f. Zip Code

21154

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

—

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

business office

16b. Kind of Business/Industry

C & P Telephone Co.

17. Father's Name (First, Middle, Last)

Thomas Gaither

Mother's Name (First, Middle, Maiden Surname)

Ruth Ferguson

19a. Informant's Name/Relationship (Type, Print)

Ruth J. Hoskins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2063 Mt. Hope Rd. Street, MD 21154

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mopland Mem. Park

Date

March 22 2000

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Krista B. Wells

22. Name and Address of Facility

Evans Funeral Chapel
3 Newport Dr. Forest Hill, MD 21050

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non small cell carcinoma-left lung 6 months

Due to (or as a consequence of):

b. Left lobar atelectasis

Due to (or as a consequence of):

c. Bone metastasis

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Right foot vascular insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Sparks

29c. License number

D 18424

29d. Date signed (Month, Day, Year)

March 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bharat Parekh M.D. 1908 Harford Road, Fallston, MD 21047

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #26 PER MEO G781 3-23-2000 WR.

Certificate of Death

Reg. No. 00 09434

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY TRIANTAFILOS JACKSON				2. Date of Death Month Day Year March 15, 2000		3. Time of Death 10100	
	4a. Facility Name (If not institution, give street and number) 2110 Lincoln Avenue				4b. City, Town, or Location of Death Edgemere		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-62-9256	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 28, 1955		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Edgemere			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2110 Lincoln Avenue			10f. Zip Code 21219		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Systems Analyst		16b. Kind of Business/Industry Health Care			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) George Soterios Triantafilos				18. Mother's Name (First, Middle, Maiden Surname) Angela Kondylas			
	19a. Informant's Name/Relationship (Type, Print) (Husband) Mr. Harold F. Jackson, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110 Lincoln Ave. Edgemere, Maryland 21219			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 3/18/2000	20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Md. 21222			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
	a. <u>OROPHARYNGEAL EDEMA, Airway obstruction</u> Due to (or as a consequence of):						1 month	
	b. <u>RECURRENT SQUAMOUS CELL CARCINOMA</u> Due to (or as a consequence of): <u>PHARYNX</u>						3 months	
	c. <u>20 RECURRENT SQUAMOUS CELL CARCINOMA</u> Due to (or as a consequence of): <u>TONGUE</u>						11 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>MAL NUTRITION</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D28133		29d. Date signed (Month, Day, Year) 3-15-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN R SANDERS, MD, 6585 W CHARLES ST BALTIMORE MD 21204								
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09435

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sidney J Leigh				2. Date of Death Month Mar Day 17 Year 2000		3. Time of Death 1:15AM	
	4a. Facility Name (If not institution, give street and number) Mariner Nursing Home				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 148-07-5988		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) April 18 1919	
	9. Birthplace (State or Foreign Country) New Jersey		10a. State VA		10b. County Fairfax		10c. City, Town or Location Springfield	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 8356 Forrester Blvd		10f. Zip Code 22152		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HUD		16b. Kind of Business/Industry Gov't			
	17. Father's Name (First, Middle, Last) Benjamin Leibowitz		18. Mother's Name (First, Middle, Maiden Surname) Fannie Polton					
	19a. Informant's Name/Relationship (Type, Print) Tracy Leigh/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1702 Summit Place NE #409 Wash DC 20009					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Everly Crematory		20c. Location - City or Town, State 3/24/00 Alexandria, VA			
	21. Signature of Funeral Service Licensee <i>[Signature]</i> Mo 11/41		22. Name and Address of Facility Everly-Wheatley Funeral Home 1500 W Braddock Rd. Alex. VA					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute myocardial infarction</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <i>2 hours</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 2 hours					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number DO 9834		29d. Date signed (Month, Day, Year) 3/17/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY ROSENBAUM 3720 FARRAGUT AVE KENSINGTON MD 20895		31. Date filed (Month, Day, Year) MAR 22 2000		32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #8 PER F.H. G781 3-23-2000 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09436

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Kirk LeRoy				2. Date of Death Month Day Year MARCH 22 2000		3. Time of Death 00:35 am			
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number 238-05-7821		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 94 Yrs.		8. Date of Birth (Month, Day, Year) November 14, 1904			
	9. Birthplace (State or Foreign Country) Baltimore, Maryland		10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Towson			
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1000 East Joppa Road Apt.304		10f. Zip Code 21286			
	10g. Citizen of What Country? United States of America				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Shell Oil Company					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Oliver Kirk				18. Mother's Name (First, Middle, Maiden Surname) Mary Ann O'Brien					
	19a. Informant's Name/Relationship (Type, Print) Mrs. Cyrilla K. Johnson(Niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 East Joppa Road Towson, Maryland 21286					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corporation		20c. Location - City or Town, State Towson, Maryland			
	21. Signature of Funeral Service Licensee Jeffrey L. Gair				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EMBOLISM Due to (or as a consequence of): b. BILATERAL LOWER EXTREMITY DEEP VENOUS THROMBOSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death ONE DAY ONE DAY		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Mamatha P. Sadda MD				29c. License number AT 2438946		29d. Date signed (Month, Day, Year) March 22nd, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAMATHA P-SADDA, UNION MEMORIAL HOSPITAL, E. UNIVERSITY BLVD., BALTIMORE, MD 21218									
	31. Date filed (Month, Day, Year) MAR 23 2000				32. Registrar's Signature Benjamin B. Spauls					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09437

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Walter Metzbower

2. Date of Death

March 20, 2000

3. Time of Death

8:40pm

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-44-3349

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 16, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

303 Oak Lane Ct.

10f. Zip Code

21286

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Industrial Engineer

16b. Kind of Business/Industry

Federal Post office

17. Father's Name (First, Middle, Last)

John Edward Metzbower

18. Mother's Name (First, Middle, Maiden Surname)

Virginia S. Green

19a. Informant's Name/Relationship (Type, Print)

Ellen R. Metzbower

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 Oak Lane Ct. Towson, MD 21286

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

March 21, 2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Heather Cain

22. Name and Address of Facility

Evans Chapel of Memories 21234
8800 Harford Rd. Baltimore, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic encephalopathy

11 days

Due to (or as a consequence of):

b. Ventricular fibrillation

11 days

Due to (or as a consequence of):

c. Coronary Artery Disease

years

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ NoHospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

March 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09438

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>James F. Mayer, Jr.</u>				2. Date of Death Month <u>March</u> Day <u>20</u> Year <u>2000</u>		3. Time of Death <u>5:00AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>2101 Southorn Rd</u>				4b. City, Town, or Location of Death <u>Middle River</u>		4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>212-50-3764</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>50</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>June 8 1949</u>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Md</u>		10b. County <u>Baltimore</u>	
To Be Completed by Funeral Director	10c. City, Town or Location <u>Middle River</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>2101 Southorn Rd</u>		10f. Zip Code <u>21220</u>	
	10g. Citizen of What Country? <u>USA</u>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>-</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>diesel mechanic</u>		16b. Kind of Business/Industry <u>construction</u>	
	17. Father's Name (First, Middle, Last) <u>James F. Mayer</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Helen E. Steek</u>		19a. Informant's Name/Relationship (Type, Print) <u>Mildred Mayer spouse</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2101 Southorn Rd. Baltimore, Md 21220</u>	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Poplar U.M. Church Ceme.</u>		20c. Location - City or Town, State <u>Cockeysville, Md</u>		20d. Date <u>March 24 2000</u>	
	21. Signature of Funeral Service Licensee <u>Kevin S. Wells</u>		22. Name and Address of Facility <u>Evans Funeral Chapel</u>		22. Name and Address of Facility <u>8800 Harford Rd Baltimore, Md 21234</u>		23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Metastatic Lung Cancer</u>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Approximate Interval Between Onset and Death <u>3 mos.</u>	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury <u>M</u> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>Robert D. Hart</u>		29c. License number <u>D39660</u>		29d. Date signed (Month, Day, Year) <u>March 22, 2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Robert C. Hart 7566 North Point Rd. Balto, Md 21219</u>		31. Date filed (Month, Day, Year) <u>MAR 23 2000</u>		32. Registrar's Signature <u>B. Sparks</u>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

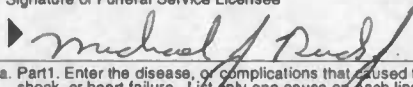
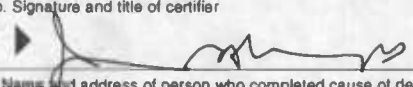

State of Maryland / Department of Health and Mental Hygiene

00 09439

AMEND ITEMS: #19B, 10C PER F.H. G781 3-27,2000 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert L. Mason				2. Date of Death Month Day Year MARCH 21 2000				3. Time of Death 11:02AM	
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 216-28-6076		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) Dec. 30, 1930		9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County TIMONIUM Baltimore		10c. City, Town or Location Lutherville Timonium	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 108 Castletown Road Unit#102				10f. Zip Code 21093				10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Field Service Representative		16b. Kind of Business/Industry Pitney Bowes Inc.					
	17. Father's Name (First, Middle, Last) Howard R. Mason, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Helen M. Carey					
	19a. Informant's Name/Relationship (Type, Print) Mrs. Elizabeth Ann Mason/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Castletown Rd. Unit#102 Lutherville, Md. 21093					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grd.		20c. Date 3/25/00		20d. Location - City or Town, State Timonium, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ATRIAL FIBRILLATION</u> Due to (or as a consequence of): b. <u>RENAL FAILURE</u> Due to (or as a consequence of): c. <u>PNEUMONIA</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>METASTATIC MOLTATE CANCER</u> <u>HYPERTENSION</u>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D15329		29d. Date signed (Month, Day, Year) 3/21/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Mersey 6505 N. Charles St. #411 Towson, MD 21204										
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

6782 4-26-00 WR.
Certificate of Death

Reg. No.

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO

00 09440

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDGAR BRUCE MORRISON III

2. Date of Death

Month Day Year
March 18, 2000

3. Time of Death

5:40 A.M.

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-46-3525

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 01 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Alleghany Co.

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1725 Frederick Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (13-16)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Chesapeake Box Co.

17. Father's Name (First, Middle, Last)

Edgar Bruce Morrison Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Sophie M. Papsan

19a. Informant's Name/Relationship (Type, Print)

Edgar B. Morrison Jr. (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1725 Frederick Street, Cumberland, Md. 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rest Haven Cemetery 3/23/2000

Date

20c. Location - City or Town, State

Hagerstown, Md.

Washington County

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

130 E. Fort Ave. Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause of each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

INTERSTITIAL MYOCARDIAL FIBROSIS

a. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COMPLICATIONS OF CERVICAL SPINE FRACTURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

8-8-88

28b. Time of
Injury

10:00

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

DECEDENT FELL DOWN STAIRS

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)

UNKNOWN

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

UNKNOWN

29e. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R. Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 18 2000

32. Registrar's Signature

Denise S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

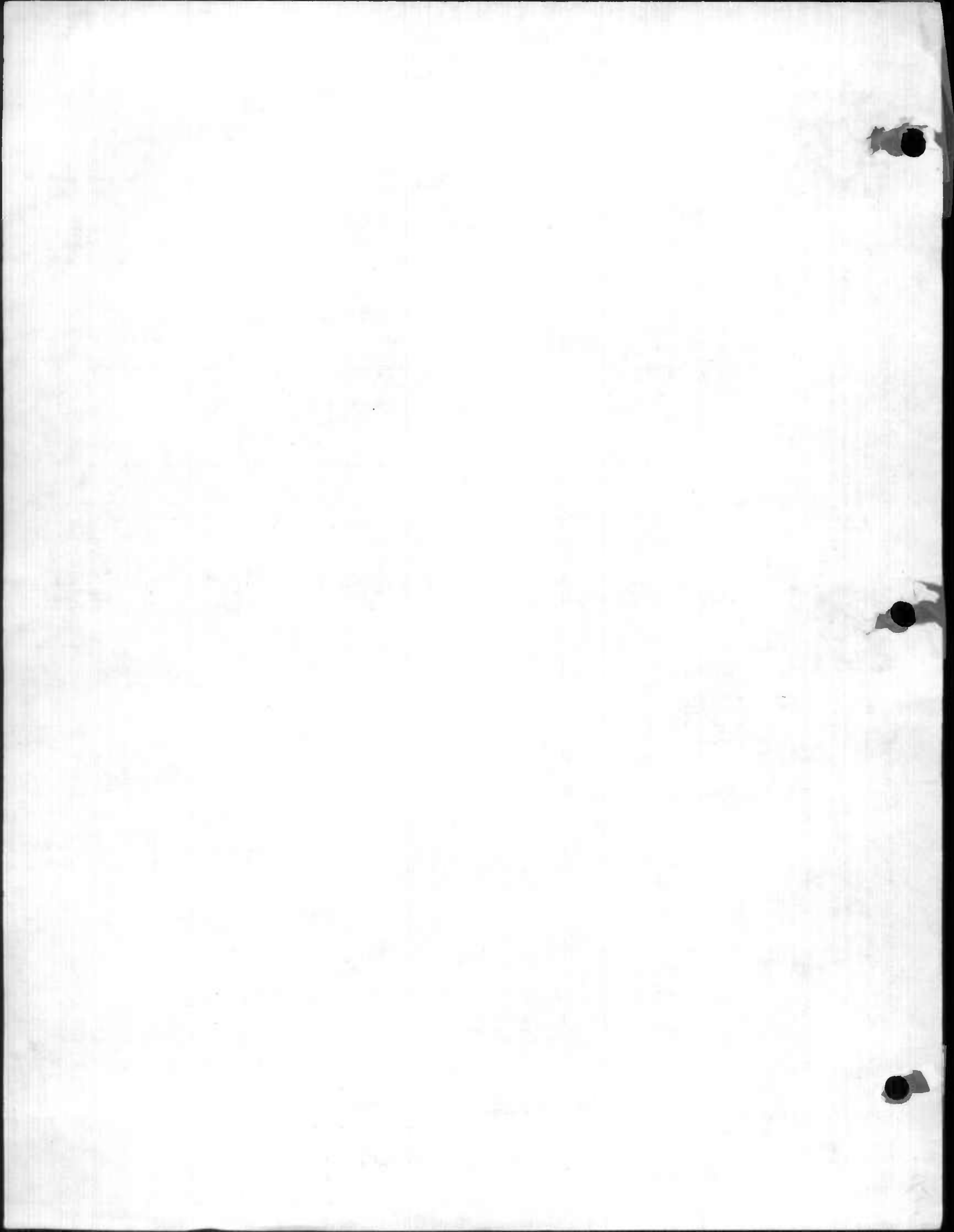
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

80 09441

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edmund Karl Parson				2. Date of Death Month March Day 18 Year 2000		3. Time of Death 5:20pm
	4a. Facility Name (If not institution, give street and number) Levindale Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death
Funeral Director	5. Social Security Number 218-90-3557	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 18, 1959	9. Birthplace (State or Foreign Country) Illinois
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Lutherville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 500 Talbott Ave.			10f. Zip Code 21093		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) disabled		16b. Kind of Business/Industry		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Edmund Leroy Parson				18. Mother's Name (First, Middle, Maiden Surname) Liselotte vonMohr		
	19a. Informant's Name/Relationship (Type, Print) Edmund L. Parson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Talbott Ave. Lutherville, MD 21093		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel-Bel Air		20c. Location - City or Town, State March 21, 2000 Forest Hill, MD 21050		
	21. Signature of Funeral Service Licensee Heather Coen		22. Name and Address of Facility Evans Chapel of memories 5800 Harford Rd. Baltimore, MD 21234				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonitis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier Raymond Miller MD			29c. License number D47683		29d. Date signed (Month, Day, Year) 3/21/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Main Street Suite 200 Pikesville, MD						
	31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature B. Sparks				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09442

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARA E. PENNEWILL

2. Date of Death

Month
MARCH

Day

21

Year

2000

3. Time of Death

02:30 AM

4a. Facility Name (If not Institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

215-07-4338

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9/29/12

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

2100 EAST JOPPA ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
WHITE15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8TH GRADE

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ASSEMBLY PERSON

16b. Kind of Business/Industry

AIR/SPACE INDUSTRY

17. Father's Name (First, Middle, Last)

LEROY ENGLE

18. Mother's Name (First, Middle, Maiden Surname)

LILLIAN WALKER

19a. Informant's Name/Relationship (Type, Print)

L. RUTH DIETER DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8911 CLEMENT AVENUE BALTIMORE, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FALLSTON METH. CH. CEM. 3/24/2000 FALLSTON, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Heather N. Hays

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.
TOWSON, MD 2128623a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. PULMONARY EMBOLUS
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 Hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA, ALZHEIMER'S TYPE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Nathan M. Rosenblum MD

29c. License number

D23319

29d. Date signed (Month, Day, Year)

MARCH 21 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

7600 OSLER DRIVE TOWSON MD 21204

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09443

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

W. A. Murton Peer

2. Date of Death

Month Day Year
MARCH 5, 2000

3. Time of Death

6:30 PM

4a. Facility Name (If not institution, give street and number)

HOMEWOOD OF FREDERICK

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

365-20-6341

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar 23, 1912

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4504 Valley View Road

10f. Zip Code

21769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 44-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (13-16)
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

editor

16b. Kind of Business/Industry

army

17. Father's Name (First, Middle, Last)

Harvey E. Peer

18. Mother's Name (First, Middle, Maiden Surname)

Florence H. Murton

19a. Informant's Name/Relationship (Type, Print)

Judith Chesley/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7407 Ridge Rd Frederick, MD 21702

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Heart Disease months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Casper E. Cline MD

29c. License number

16428

29d. Date signed (Month, Day, Year)

3/7/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CASPER E CLINE MD 31 West Patrick Street

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09444

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Raymond Rose, Sr.				2. Date of Death Month March Day 18 Year 2000		3. Time of Death 10:06 am	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-36-1555		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 31, 1940	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2715 Glendale Rd.		10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Towson University				
17. Father's Name (First, Middle, Last) Clarence E. Rose, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Kielholtz				
19a. Informant's Name/Relationship (Type, Print) Susan M. Rose - Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2715 Glendale Rd. Baltimore, MD 21234				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus		20c. Location - City or Town, State Highlandtown, MD		20d. Date March 22, 2000		
21. Signature of Funeral Service Licensee Heather Cain				22. Name and Address of Facility Evans Chapel of Memories 21234 8800 Harford Road Baltimore, MD				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. ACUTE MYOCARDIAL INFARCTION					Approximate Interval Between Onset and Death MINUTES	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):						
		b. HYPERTENSION						
		Due to (or as a consequence of):						
		c. HYPERLIPIDEMIA						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. Fernando J. Ferraz MD		29c. License number D40480		29d. Date signed (Month, Day, Year) MARCH 20, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO J. FERRAZ MD		7672 BELAIR RD BALTO, MD 21236						
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature Genevieve B. Sparks						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09445

Matthew Reznick March 16, 2000 1:00 P.M.
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Matthew P. Reznick				2. Date of Death Month Day Year March 16 2000		3. Time of Death 1:00 pm	
4a. Facility Name (If not institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore	
5. Social Security Number 215-14-8219		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Nov 30 1922	
9. Birthplace (State or Foreign Country) Maryland		10a. State Md		10b. County Baltimore		10c. City, Town or Location Towson	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1 Smeton Place #805		10f. Zip Code 21204		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) barber		16b. Kind of Business/Industry Hair Salon			
17. Father's Name (First, Middle, Last) John Reznick				18. Mother's Name (First, Middle, Maiden Surname) Bessie Hudzik			
19a. Informant's Name/Relationship (Type, Print) Eleanor Reznick spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Smeton Place #805 Towson, Maryland 21204			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harrison Forest Cemetery		20c. Location - City or Town, State March 21 2000 Harrison Maryland		20d. Date	
21. Signature of Funeral Service Licensee Kevin S. Woll				22. Name and Address of Facility Evans Funeral Chapel 2325 York Rd. Timonium, Maryland 21093			

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GASTRIC CANCER				Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)				Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Due to (or as a consequence of):			
Due to (or as a consequence of):				Due to (or as a consequence of):			
Due to (or as a consequence of):				Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Dr. Tariq Mahmood				29c. License number D43725		29d. Date signed (Month, Day, Year) 3/17/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093							
31. Date filed (Month, Day, Year) MAR 23 2000				32. Registrar's Signature B. Sparks			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09446

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Aolia Anna Molvina Smith

2. Date of Death

March 20 2000

3. Time of Death

6:15 p.m.

4a. Facility Name (If not institution, give street and number)

Franklin Woods Nursing Home

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-36-8662

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 2, 1907

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

203 Riverton Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

William Masson

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Volz

19a. Informant's Name/Relationship (Type, Print)

Linda M. Magsamen - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

203 Riverton Road, Baltimore, MD 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Orens United Meth. Ch. Cemetery 3/23/2000

Date

20c. Location - City or Town, State

Essex, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAFA, Stephen D. Lohrmann, P.A.
8717 Green Pastures Drive, Towson, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Aspiration Pneumonia

2 weeks

Due to (or as a consequence of):

b. Right Cerebrovascular accident

90 days

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28949

29d. Date signed (Month, Day, Year)

3/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Panayiotis Baltatzis, M.D. 1232 Race Road, Rosedale, MD 21237

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-333-6000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHHM 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09447

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ethel</i>		2. Date of Death Month <i>MARCH</i> Day <i>13</i> Year <i>2000</i>		3. Time of Death <i>21:42</i>
	4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center Baltimore</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>
Funeral Director	5. Social Security Number <i>214-28-0490</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>75</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>06/11/24</i>	9. Birthplace (State or Foreign Country) <i>Raleigh, NC</i>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <i>4320 Clareway, Apt. 2B</i>		10f. Zip Code <i>21213</i>		10g. Citizen of What Country? <i>USA</i>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (14 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Cook</i>		16b. Kind of Business/Industry <i>Self Employed</i>		
	17. Father's Name (First, Middle, Last) <i>James Powell</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Luna Pratt</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Novella Quarries</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1909 Sud Creek Dr., Baltimore, MD</i>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery</i>		20c. Location - City or Town, State <i>3/18/00 Baltimore, MD</i>
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>Willie Howell, per DVR</i>		22. Name and Address of Facility <i>Howell Funeral Home, 4600 Lieberly Hgts. Ave. Balto., MD 21207</i>		
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) a. <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i> Due to (or as a consequence of): b. <i>PULMONARY EMBOLISM</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>
	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D26233</i>		29d. Date signed (Month, Day, Year) <i>MARCH 17, 2000</i>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>FRANCIS KUHNATTA Johns Hopkins Bayview Medical Center Baltimore MD 21224</i>				
	31. Date filed (Month, Day, Year) <i>MAR 23 2000</i>		32. Registrar's Signature <i>[Signature]</i>		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09448

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Isidore P. Trovato				2. Date of Death Month Day Year March 17, 2000		3. Time of Death 3:00pm	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-07-2391		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) April 12, 1922	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4332 Roland Avenue		10f. Zip Code 21210		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 + College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector		16b. Kind of Business/Industry City of Balto		17. Father's Name (First, Middle, Last) Joseph Trovato		
18. Mother's Name (First, Middle, Maiden Surname) Carmella Tomarchio		19a. Informant's Name/Relationship (Type, Print) Patricia Ernst (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4332 Roland Avenue Balto, MD 21210		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		20c. Date 3/21		20d. Location - City or Town, State Fullerton, MD		21. Signature of Funeral Service Licensee <i>Michael Carpenter</i>		
22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Colonic Carcinoma Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): Senile Dementia Due to (or as a consequence of):		Approximate Interval Between Onset and Death 1 year		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier RAMESH SABAPATHI		29c. License number D30641		29d. Date signed (Month, Day, Year) March 20 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back River Neck Road Baltimore MD 21221		
31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature <i>B. Sparks</i>		State Registrar		DHMH 16 Rev 5/95		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09449

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JUANITA TUCKER		2. Date of Death Month Day Year MARCH 19, 2000		3. Time of Death 8:25 PM
	4a. Facility Name (If not institution, give street and number) STELLA MARIS AT MERCY HOSPICE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 212-48-3526	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birth day) 50 Yrs.	8. Date of Birth (Month, Day, Year) JAN. 29, 1950	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 706 NORTH COLLINGTON AVE.		10f. Zip Code 21205		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER		16b. Kind of Business/Industry OWN HOME
	17. Father's Name (First, Middle, Last) GEORGE ROY		18. Mother's Name (First, Middle, Maiden Surname) BERNICE JOBES		
	19a. Informant's Name/Relationship (Type, Print) PAMELA GAMBRILL (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 E. MADISON ST., APT #7, BALTO, MD. 21205		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK 03-27-00		20c. Location - City or Town, State WOODLAWN, MARYLAND
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) a. Cervical Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Approximate Interval Between Onset and Death 1 year				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier MD		29c. License number D38675		29d. Date signed (Month, Day, Year) 3/20/2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL MESHULAM 301 ST PAUL BL BALTIMORE MD 21202				
	31. Date filed (Month, Day, Year) MAR 23 2000		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09450

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary L. Taylor					2. Date of Death Month: March Day: 22, Year: 2000		3. Time of Death 4:00 am			
	4e. Facility Name (If not institution, give street and number) 1502 Aldeney Ave					4b. City, Town, or Location of Death Middle River		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 220-36-3139		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) August 25, 1923		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD		10b. County Baltimore		10c. City, Town or Location Middle River				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1502 Aldeney Ave					10f. Zip Code 21220		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Wilmer Crouch					18. Mother's Name (First, Middle, Maiden Surname) Edith L. Horten						
19a. Informant's Name/Relationship (Type, Print) Bill Taylor / son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1502 Aldeney Ave Middle River, MD 21220						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc		Date 3-24-2000		20c. Location - City or Town, State Beltsville, MD				
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility CAFA Stephen D. Lohmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic non-small Lung CA</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 5 mo		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number D36814		29d. Date signed (Month, Day, Year) 3/22/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Richard L. Hushig 1505 Osler Dr, Suite 302 Towson MD 21204</i>											
31. Date filed (Month, Day, Year) MAR 23 2000			32. Registrar's Signature <i>[Signature]</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Mary TAYLOR
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

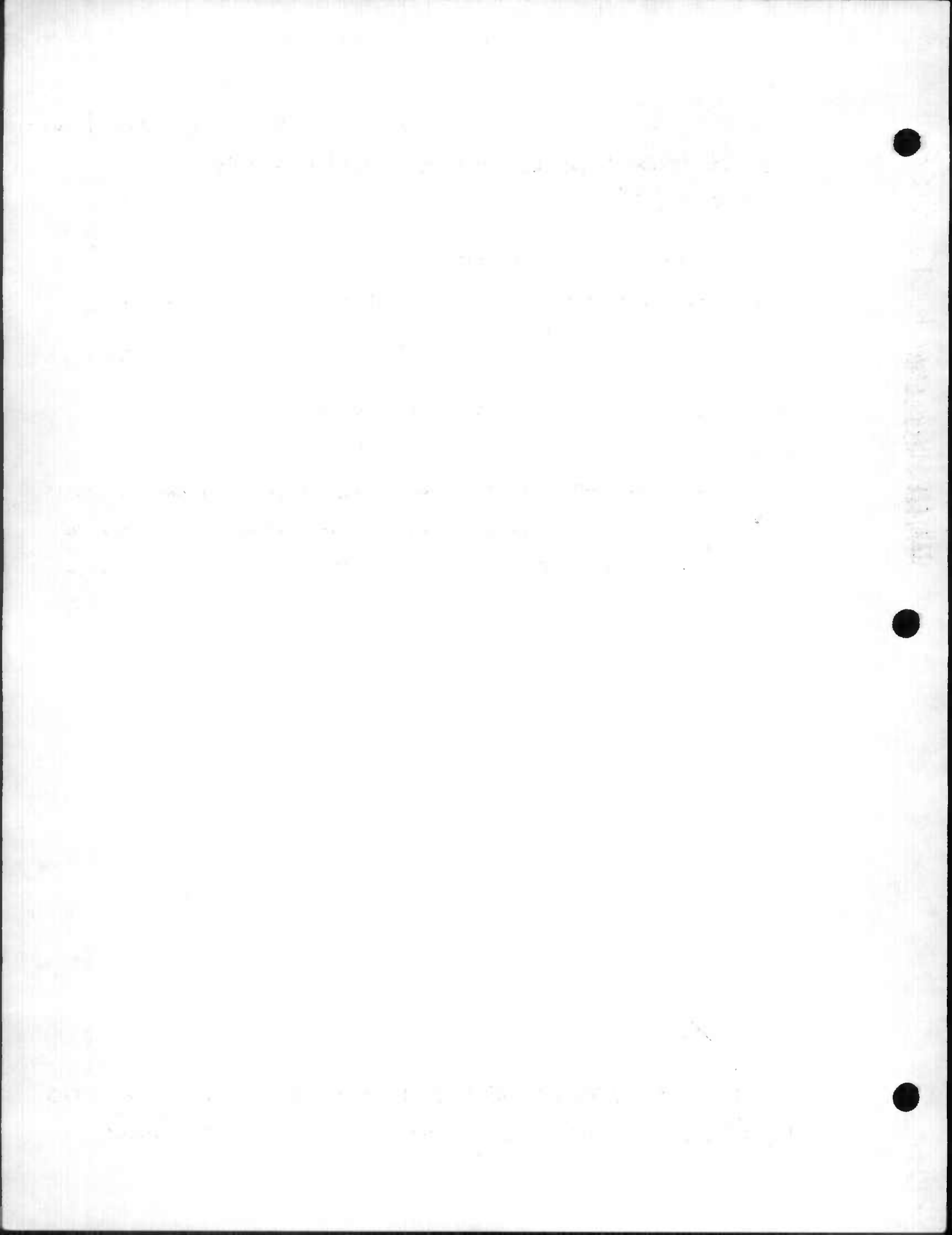
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09451

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kirk Wise				2. Date of Death Month March Day 12 Year 2000		3. Time of Death 4:56pm	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore City		4c. County of Death	
Funeral Director	5. Social Security Number 212-88-5600		6. Sex 10 M 2 F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12 04 64	9. Birthplace (State or Foreign Country) M.D.
	Usual Residence of Decedent				10a. State MD		10b. County NA	
To Be Completed by Funeral Director	10c. City, Town or Location Baltimore				10d. Inside City Limits 1 X Yes 2 No		10e. Street and Number 6810 Park Height Ave	
	10f. Zip Code 21215				10g. Citizen of What Country? U.S.A.		11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) lyr				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Operator		16b. Kind of Business/Industry School	
	17. Father's Name (First, Middle, Last) Henry Wise				18. Mother's Name (First, Middle, Maiden Surname) Lottie Downs			
	19a. Informant's Name/Relationship (Type, Print) Lottie Lee Johnson-Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6810 Park Height Ave, Baltimore Md 21215			
	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens 3-20-00 Baltimore, Md		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Acute on Chronic Renal Failure Due to (or as a consequence of): b. Line Sepsis, Venous Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death unknown one week				23b. Did tobacco use contribute to the cause of death? 1 No 2 Yes 3 Probably 4 Unknown			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin dependent diabetes mellitus				24a. Was an autopsy performed? 1 Yes 2 X No			
25. Was case referred to medical examiner? 1 Yes 2 X No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				28a. Date of Injury (Month, Day, Year) March 12 2000		28b. Time of Injury M		
28c. Injury at Work? 1 Yes 2 No				28d. Describe how injury occurred				
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Ugachi Erundu M.D. RES-000				
29c. License number RES-000				29d. Date signed (Month, Day, Year) March 12 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ugachi Erundu, M.D. Sinai Hospital, 2401 West Belvedere Avenue, Baltimore, Maryland 21215				31. Date filed (Month, Day, Year) MAR 23 2000				
32. Registrar's Signature [Signature]				33. State Registrar State Registrar				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09452

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel Wieczynski

2. Date of Death

March 20 2000

3. Time of Death

8:20 A

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-16-1720

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 28, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2924 Sollers Point Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 Year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Correctional Officer

16b. Kind of Business/Industry

Maryland State

Penal System

17. Father's Name (First, Middle, Last)

Boleslaus Wieczynski

18. Mother's Name (First, Middle, Maiden Surname)

Eva Jaworski

19a. Informant's Name/Relationship (Type, Print) (Wife)

Mrs. Laura V. Wieczynski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2924 Sollers Point Road Dundalk, MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gdns. 3/23/2000

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

E. R. Ruck

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory Failure

Due to (or as a consequence of):

1 wk

c. Renal Failure

Due to (or as a consequence of):

5 mos

d. Sepsis

Due to (or as a consequence of):

5 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P bowel resection ischemic bowel

wound infection/dehiscence

MRSA Sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

W. B. Greenough MD

29c. License number

12043 83

29d. Date signed (Month, Day, Year)

March 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. B. Greenough MD

Johns Hopkins Bayview Med Ctr
4940 Eastern Ave
Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAR 23 2000

Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09453

AMENDED ITEM #5 PER FH G781 3/23/2000 AH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM A WOODS		2. Date of Death Month Day Year MARCH 15, 2000		3. Time of Death 2:30 AM
	4a. Facility Name (If not institution, give street and number) Baltimore Rehabilitation and Extended Care		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 213-46-0308	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	8. Date of Birth (Month, Day, Year) Aug. 24, 1925	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 1010 West Baltimore St		10f. Zip Code 21223		10g. Citizen of What Country? US
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE		16b. Kind of Business/Industry CITY OF BALTIMORE
	17. Father's Name (First, Middle, Last) Joseph Berry		18. Mother's Name (First, Middle, Maiden Surname) Virginia Thompson		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Rosalind V. Jones / daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5007 Schaub Ave Baltimore, MD 21206		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON Forest		20c. Location - City or Town, State 3-20-00 Owings Mills, MD
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L P.K.E. BALTO. MD 21229		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Myeloma				
	Approximate Interval Between Onset and Death 1 year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature] MD					
29c. License number D0032548					
29d. Date signed (Month, Day, Year) March 15, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Perry L Colvin Baltimore, Maryland					
31. Date filed (Month, Day, Year) MAR 23 2000					
32. Registrar's Signature [Signature]					

ORIGINAL

1945-1946

1947-1948

1949-1950

1951-1952

1953-1954

1955-1956

1957-1958

1959-1960

1961-1962

1963-1964

1965-1966

1967-1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMENDED ITEM 20b PER FH G781 3/23/2000 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DARRYL T. WADE

2. Date of Death

March 20, 2000

3. Time of Death

0338

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

Funeral
Director

5. Social Security Number

213-90-7824

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-13-1963

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3907 ROXANNE RD.

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

-12-

College (1-4 or 5+)

-0-

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

MCI

17. Father's Name (First, Middle, Last)

SAMUEL WADE

18. Mother's Name (First, Middle, Maiden Surname)

ALMA SADDLER

19a. Informant's Name/Relationship (Type, Print)

SAMUEL WADE (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3907 ROXANNE RD. RANDALLSTOWN, MARYLAND 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)ARBUTUS MEMORIAL PARK
KING MEMORIAL PARK

Date

3-24-2000 BALTIMORE, MARYLAND

21. Signature of Funeral Service

Vernon R. Bailey

22. Name and Address of Facility

VERNON R. BAILEY FUNERAL SERVICE
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. SEVERE CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. AIDS

Due to (or as a consequence of):

c. CHRONIC RENAL FAILURE

Due to (or as a consequence of):

d. SEPSIS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

m. g. [Signature]

29c. License number

DS23 23

29d. Date signed (Month, Day, Year)

3/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KH ALID WASREM 19414 C LINTERSBURG PKW HAGERSTOWN MD 21742

State
Registrar

31. Date filed (Month, Day, Year)

MAR 23 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
0005.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

000-09455

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) LILLIE AUGHINBAUGH		2. Date of Death Month March Day 14 Year 2000		3. Time of Death 6:00 PM	
4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's	
5. Social Security Number 216-48-9512		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.	
8. Date of Birth (Month, Day, Year) Apr. 5, 1913		9. Birthplace (State or Foreign Country) Kentucky			
Usual Residence of Decedent					
10a. State Maryland		10b. County Prince George		10c. City, Town or Location Laurel	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 14608 Stratfield Circle		10f. Zip Code 20707		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Eugene Gish		18. Mother's Name (First, Middle, Maiden Surname) Florence King			
19a. Informant's Name/Relationship (Type, Print) Joyce Atkins/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14608 Stratfield Circle Laurel, Maryland 20707			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington Park East		20c. Location - City or Town, State 3/18/00 Indianapolis, Indiana	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Infection Myocardial, Infarction Due to (or as a consequence of): b. Coronary Atherosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 1 day			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Andrew Kunrat M.D.		29c. License number 036716		29d. Date signed (Month, Day, Year) March 15th, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kunrat, M.D. 8317 Cherry Lane, Laurel, Md. 20775					
31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature Benita B. Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Page 1 of 1

1. Introduction

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3. Methodology

4. Results

5. Conclusion

6. References

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26. Index

27. Bibliography

28. Appendix

29. Acknowledgements

30. Contact Information

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09456

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Victoria R. E. Anthony				2. Date of Death Month Day Year March 18, 2000				3. Time of Death 2:55 am	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 076-56-9265		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) July 4, 1919		9. Birthplace (State or Foreign Country) Guyana	
	Usual Residence of Decedent									
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 10802 New Hampshire Avenue				10f. Zip Code 20903				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Care				16b. Kind of Business/Industry Health		
17. Father's Name (First, Middle, Last) Nathaniel Bowen						18. Mother's Name (First, Middle, Maiden Surname) Sarah Pinheiro				
19a. Informant's Name/Relationship (Type, Print) George Anthony Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4417 Avenue K Brookland, New York 11234						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Lawn Memorial Park		Date 3-25-00		20c. Location - City or Town, State Pine Lawn, New York		
21. Signature of Funeral Service Licensee <i>[Signature]</i> MD1142				22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707						
23a. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION 5 weeks										
Due to (or as a consequence of): b. ISCHEMIC CARDIOMYOPATHY 5 yrs										
Due to (or as a consequence of): c. DIFFUSE ARTERIOSCLEROSIS 5 yrs										
Due to (or as a consequence of): d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE ACUTE CEREBROVASCULAR ACCIDENT								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D28195		
				29d. Date signed (Month, Day, Year) 3-18-2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID A. GORDAY, MD. 1450 MERCANTILE LN. LARGO, MD. 20774										
31. Date filed (Month, Day, Year) MAR 24 2000				32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State
Registrar

THE
OFFICE OF THE
DIRECTOR
OF THE
BUREAU OF
THE
LAND OFFICE
WASHINGTON
D. C.

TO THE
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State of Maryland / Department of Health and Mental Hygiene 00 09457

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Eugene Allbrooks</i>		2. Date of Death Month <i>March</i> Day <i>20</i> Year <i>2000</i>		3. Time of Death <i>1:10 PM</i>
	4a. Facility Name (If not institution, give street and number) St. Joseph's Hospital		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 153-22-3027	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Nov. 19 1930		9. Birthplace (State or Foreign Country) New Jersey		
Usual Residence of Decedent					
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baldwin	
10e. Street and Number 13324 Manor Road		10f. Zip Code 21013		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: '53-'55		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator		16b. Kind of Business/Industry Public Administration			
17. Father's Name (First, Middle, Last) Leslie Forbes Allbrooks			18. Mother's Name (First, Middle, Maiden Surname) Catherine Marie Wilkisson		
19a. Informant's Name/Relationship (Type, Print) Anne M. Allbrooks/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13324 Manor Rd., Baldwin, MD 21013		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Balto. Wash. Crematory		20c. Location - City or Town, State Laurel, MD	
21. Signature of Funeral Service Licensee <i>Lowell M. Lemmon</i>		22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Cardiac Arrhythmia</i> Due to (or as a consequence of): <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Charles F. O'Donnell MD</i>		29c. License number D-09383		29d. Date signed (Month, Day, Year) March 20, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles F. O'Donnell MD 111 Hamilton Hill Rd Baltimore MD 21210					
31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature <i>B. Sparks</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09458

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lynette Mock Anderson

2. Date of Death

March 20, 2000

3. Time of Death

1230pm

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-30-6966

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 13 1933

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1333 Bolton Street

10f. Zip Code

21217

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Social Worker

16b. Kind of Business/Industry

Private Agency

17. Father's Name (First, Middle, Last)

Clark Mock

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Brown

19a. Informant's Name/Relationship (Type, Print)

Rev. Wallace W. Anderson / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1333 Bolton Street Baltimore, Maryland 21217

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

3/22/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Steven T. Buttle

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Intracerebral Bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Akash Taggar

29c. License number

89358

29d. Date signed (Month, Day, Year)

20 MAR 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Akash Taggar, M.D. 90 Maryland General Hospital

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

B. Sparks

State
Registrar



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 09459

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cathryn M. Bowen					2. Date of Death Month Day Year MAR 20 2000			3. Time of Death 10:15 PM		
	4a. Facility Name (If not institution, give street and number) ST Agnes Hospital					4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A		
Funeral Director	5. Social Security Number 213-16-3599		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) March 23, 1919		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1211 Circle Drive					10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Telephone Company			
	17. Father's Name (First, Middle, Last) Lawrence Francis Milan, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Katherine Rose Rasasco					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Louis M. Milan, Sr./ Brother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 Sunshine Street, Glen Burnie, Maryland 21061					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 3-24-2000		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee [Signature]					22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 10 days
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RESPIRATORY DISTRESS SYNDROME Renal Failure							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier [Signature]					29c. License number D 47484			29d. Date signed (Month, Day, Year) MAR 20, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIK K SHEPARD MD 900 CATON AVE BALTIMORE, MD 21229											
31. Date filed (Month, Day, Year) MAR 24 2000			32. Registrar's Signature [Signature]								

ORIGINAL

April 22

April 22 - 1914

April 22 - 1914

April 22 - 1914

April 22 - 1914

April 22 - 1914

April 22 - 1914

April 22 - 1914

April 22 - 1914

April 22 - 1914

April 22 - 1914

April 22 - 1914

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09460

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anthony Joseph Bechler, Jr.				2. Date of Death Month Day Year 03 20 2000		3. Time of Death 12:30pm		
	4a. Facility Name (If not institution, give street and number) 305 Wessling Circle				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 219-26-7380		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) May 6, 1938		
	9. Birthplace (State or Foreign Country) MD.		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Catonsville		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 305 Wessling Circle		10f. Zip Code 21228		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insulation Superintendent		16b. Kind of Business/Industry Colt Insulation				
	17. Father's Name (First, Middle, Last) Anthony Joseph Bechler Sr.				18. Mother's Name (First, Middle, Maiden Surname) Estella Mary Heusler				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Anthony J. Bechler Jr. Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10222 Liberty Rd. Frederick, MD. 21701				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Balto. Wash. Crematory		20c. Location - City or Town, State Laurel, MD.		20d. Date 03/25		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Robert J. Rodard				22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Balto, MD. 21228				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Bronchogenic Carcinoma, now small Carcinoma</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 3 months	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Skeletal metastases, Multiple Thrombophlebitis</i>							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier Joseph H Miller MD		29c. License number 006982		29d. Date signed (Month, Day, Year) March 21, 2000				
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH H MILLER MD 900 CATON AVE BALTIMORE MD 21229								
	31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature B. Sparks						

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09461

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jay Vernon Beavers, Sr.

2. Date of Death

March 22, 2000

3. Time of Death

12:30pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

235-34-8794

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 14, 1927

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6922 University Drive

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cable Repairman

16b. Kind of Business/Industry

Merchant Marine

17. Father's Name (First, Middle, Last)

Wade Beavers

18. Mother's Name (First, Middle, Maiden Surname)

Rene Christian

19a. Informant's Name/Relationship (Type, Print)

Deborah Winkler (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6922 University Drive, Baltimore, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holly Hill Mem. Gardens 3/24/2000 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Bruzdinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Septic Shock
Due to (or as a consequence of):

12 Hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Pneumonia
Due to (or as a consequence of):c. Squamous cell Lung Cancer
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Kauser Khan, MD

29c. License number

RD 198879

29d. Date signed (Month, Day, Year)

March 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Kauser Khan 9000 Franklin Square Drive Baltimore, MD. 21237

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09462

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN E BEAN

2. Date of Death

Month Day Year
MARCH 22, 2000

3. Time of Death

09:34

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

241-44-1652

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/19/1928

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6508 Cleveland Ave.

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Luther Monroe Earnhardt

18. Mother's Name (First, Middle, Maiden Surname)

Rena Brady

19a. Informant's Name/Relationship (Type, Print)

Christian Morris/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6508 Cleveland Ave, Balto, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens Timonium, Md.

Date

3-25-00

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert J. Proch...

22. Name and Address of Facility

Bradley-Ashton-Matthews Funeral Home, Inc.
2134 Willow Spring Rd., Balto., Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. UROSEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, CORONARY ARTERY DISEASE WITH MYOCARDIAL

INFARCTION, ATRIAL FIBRILLATION, CEREBROVASCULAR

ACCIDENT x 2, ABDOMINAL AORTIC ANEURYSM.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Srinivas K. Prasad, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MARCH 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SRINIVAS K. PRASAD, MD. JOHNS HOPKINS BAYVIEW MEDICAL CENTER

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

Srinivas K. Prasad

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09463

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elisha A. Baker Jr.				2. Date of Death Month 03 Day 22 Year 00			3. Time of Death 4:00 PM		
	4a. Facility Name (If not institution, give street and number) 938 W. Saratoga St.				4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A		
Funeral Director	5. Social Security Number 406-44-6842		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	8. Date of Birth (Month, Day, Year) May 5, 1933		9. Birthplace (State or Foreign Country) Kentucky			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 938 W. Saratoga St.				10f. Zip Code 21223		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaping			16b. Kind of Business/Industry Hammonds Landscaping				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Elisha A. Baker, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Jester Kimbrow					
	19a. Informant's Name/Relationship (Type, Print) (wife) Mrs. Sarah Baker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2007 Guilford Ave. Balto. Md. 21202					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest			20c. Location - City or Town, State 3/24/00 Owings Mills, Md.				
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BLADDER CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 6 MONTHS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier [Signature]				29c. License number P-11195		29d. Date signed (Month, Day, Year) 3/24/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL PALESE, MD BALTIMORE VETERANS AFFAIRS HOSPITAL									
	31. Date filed (Month, Day, Year) MAR 24 2000				32. Registrar's Signature [Signature]					

State of Maryland / Department of Health and Mental Hygiene 00 09464
Certificate of Death Reg. No.

Reg. No.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09465

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT

P.

BLOOM

2. Date of Death

Month

Day

Year

3. Time of Death

10:50 PM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-09-0910

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

SEP. 5, 1909

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6203 WESTERN RUN DRIVE

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

BUYER

16b. Kind of Business/Industry

FURNITURE

17. Father's Name (First, Middle, Last)

JACOB

BLOOM

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

GALANTER

19a. Informant's Name/Relationship (Type, Print)

JACOB BLOOM / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 WHITEBRIDGE COURT - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ANSHE EMUNAH (AITZ CHAIM)

Date

3/23/00

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Paul Schwartz

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. ISCHEMIC HEART DISEASE

Due to (or as a consequence of):

c. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

ACUTE

YEARS

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END-STAGE PARKINSON'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert E. Roby M.D.

29c. License number

D-19425

29d. Date signed (Month, Day, Year)

3/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT E. ROBY M.D. - 2211 W. ROGERS AVE - BALTIMORE, MD 21209

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

G. Sparks

State Registrar

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 09466**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **KATE EVELYN CREASY** 2. Date of Death Month **(MARCH) 3** Day **20** Year **2000** 3. Time of Death **7:20 PM**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **SHOCK TRAUMA CENTER** 4b. City, Town, or Location of Death **BALTIMORE,** 4c. County of Death **BALTIMORE**

5. Social Security Number **321-80-5249** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **22** Yrs. 8. Date of Birth (Month, Day, Year) **2/27/78** 9. Birthplace (State or Foreign Country) **ILLINOIS**

Usual Residence of Decedent 10a. State **IL.** 10b. County **Cook** 10c. City, Town or Location **Lynwood** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **20235 Burnham Ave.** 10f. Zip Code **60411** 10g. Citizen of What Country? **USA**

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **2** College (1-4 or 5+) **2** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Student** 16b. Kind of Business/Industry **School**

17. Father's Name (First, Middle, Last) **Dale Creasy** 18. Mother's Name (First, Middle, Maiden Surname) **Linda Bronder**

19a. Informant's Name/Relationship (Type, Print) **Linda Creasy - Mother** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **20235 Burnham Ave. Lynwood, IL. 60411**

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Tri-County Crematory** Date **03/27** 20c. Location - City or Town, State **Channahon, IL.**

21. Signature of Funeral Service Licensee **Robert Creasy** 22. Name and Address of Facility **Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD. 21228**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **a. severe anoxic brain injury** Due to (or as a consequence of): **b. head injuries** Due to (or as a consequence of): **c.** Due to (or as a consequence of): **d.** Approximately Interval Between Onset and Death

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☐ Natural ☒ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) **3/17/00** 28b. Time of Injury **4 24 PM** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred **AUTO ACCIDENT**

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **STREET** 28f. Location (Street and Number or Rural Route Number, City or Town, State) **EGYPT + OLDFIELD RD, MD**

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Kerry Kole D.O.** 29c. License number **80055103** 29d. Date signed (Month, Day, Year) **March 20 2000**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Kerry Kole 22 South Greenstreet Baltimore, Maryland 21201**

31. Date filed (Month, Day, Year) **MAR 24 2000** 32. Registrar's Signature **P. Sparks**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#1 PER MD. & 12&19a PER F.H. G782 4-26-2000 JAB

Certificate of Death

Reg. No.

00 09467

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James

Cook

JAMES FINLEY COOK, JR.

2. Date of Death

March

23

2000

3. Time of Death

5:15am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Geriatric Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

407-36-1867

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day, Year)

MAY 22, 1930

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

KY

10b. County

Laurel

10c. City, Town or Location

London

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

310 Washington Street

10f. Zip Code

40741

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1950 - 5413. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Auto Parts

17. Father's Name (First, Middle, Last)

James Finley Cook, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mona Bennett Sipple

19a. Informant's Name/Relationship (Type, Print)

Latane G. Cook, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

310 Washington St., London, Kentucky 40741

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

A. R. Dyché Memorial Pk.

Date

3/26/00

20c. Location - City or Town, State

London, Kentucky

21. Signature of Funeral Service Licensee

Mgt. Marshall

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkrige, Md. 2107523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Malignant brainstem glioma

8 months

Due to (or as a consequence of):

b. Carcinomatous meningitis

8 months

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

respiratory insufficiency, hypothyroidism
depression, MRSA colonization, prostate
cancer, aspiration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Beamer MD

29c. License number

D47479

29d. Date signed (Month, Day, Year)

3/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Brock Allen Beamer - Johns Hopkins Hospital - Baltimore, MD.

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09468

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Selma O. Carton				2. Date of Death Month 03 Day 18 Year 00		3. Time of Death 3:15 PM			
	4a. Facility Name (If not institution, give street and number) Vantage House CCRC 5400 Vantage Pt. Rd.				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard			
Funeral Director	5. Social Security Number 214-05-0140		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 30, 1915		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
10a. State MD		10b. County Howard		10c. City, Town or Location Columbia				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5400 Vantage Pt., Road				10f. Zip Code 21044		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Frank Ossry					18. Mother's Name (First, Middle, Maiden Surname) Anna Klaff					
19a. Informant's Name/Relationship (Type, Print) Joseph S. Carton/Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 Vantage Pt. Road, Columbia, MD 21044					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Kneseth Israel Cemetery		Date 03/19/2000		20c. Location - City or Town, State Annapolis, MD			
21. Signature of Funeral Service Licensee Michael P. Tuttle					22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic adenocarcinoma. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 4 months		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier William Flowers MD					29c. License number D20789		29d. Date signed (Month, Day, Year) 3-19-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Flowers MD 11055 Little Patuxent Columbia										
31. Date filed (Month, Day, Year) MAR 24 2000			32. Registrar's Signature B. Sparks							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09469

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA CASH				2. Date of Death Month Day Year MARCH 22, 2000				3. Time of Death 1301				
	4a. Facility Name (If not institution, give street and number) ST. AGNES HEALTHCARE 900 CATON AVENUE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death				
Funeral Director	5. Social Security Number 213-24-9317		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Nov. 11, 1928	9. Birthplace (State or Foreign Country) PA	
	Usual Residence of Decedent												
10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 10170 Hobsons Choice Ln.				10f. Zip Code 21042				10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Key punch operator				16b. Kind of Business/Industry Garment					
17. Father's Name (First, Middle, Last) Ross Weaver						18. Mother's Name (First, Middle, Maiden Surname) Mary Loehman							
19a. Informant's Name/Relationship (Type, Print) Harold L. Cash, husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10170 Hobsons Choice Ln. Ellicott City, MD. 21042							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Shanks Church of the Brethren Cemetery				Date 3-25-00		20c. Location - City or Town, State Greencastle, PA			
21. Signature of Funeral Service Licensed <i>[Signature]</i>				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227									
23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>acute myocardial infarction</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number 033061			29d. Date signed (Month, Day, Year) March 22, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Scannine Saunders St Agnes Hospital Baltimore</i>													
State Registrar		31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature <i>[Signature]</i>									

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09470

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNETTE VASSELL COMENETZ

2. Date of Death

03 23 2000

3. Time of Death

0230

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Arundel

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

A. A.

5. Social Security Number

191-32-7465

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 9, 1909

9. Birthplace (State or Foreign Country)

Poland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

800 Bestgate Road
1309 Lloyd Court

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+ 5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

High School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Srul Myer Hazenszprung

18. Mother's Name (First, Middle, Maiden Surname)

Eva Wassercug (Vassell)

19a. Informant's Name/Relationship (Type, Print)

Michael Comenetz (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1309 Lloyd Court, Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

03/24

2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Michael D. Kutta

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPERNATREMIC DEHYDRATION

100

Due to (or as a consequence of):

b. DIABETES MELLITUS, TYPE 2

57

Due to (or as a consequence of):

c. STROKE

years

Due to (or as a consequence of):

d. HYPERTENSION

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Jelenian

29c. License number

D21438

29d. Date signed (Month, Day, Year)

Mar 23 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. JELIAN 600 RIDGELY AVENUE STE 120 ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

John B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09471

AMEND #1 PER MD. G781 3-24-2000 JAB

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

SOPHIE CONNER

2. Date of Death

Month Day Year

3. Time of Death

March 6 2000 6:00pm

4a. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

4c. County of Death

The Johns Hopkins Hospital Baltimore City 7 N/A

5. Social Security Number

220-30-1442

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 30, 1914

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

817 St. Paul Street #709

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

unit clerk

16b. Kind of Business/Industry

hospital

17. Father's Name (First, Middle, Last)

Thomas P. Connor

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Bayliss

19a. Informant's Name/Relationship (Type, Print)

John Hopkins Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

600 N. Wolfe Street Baltimore, MD 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Acute Myelogenous Leukemia
Due to (or as a consequence of):

2 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Myelodysplastic Syndrome
Due to (or as a consequence of):

6 months

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28d. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dana Portnow MD

29c. License number

D0053856

29d. Date signed (Month, Day, Year)

March 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Hospital 600 North Wolfe Street Baltimore, Maryland 21287

State
Registrar

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

Benjamin P. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09472

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarke, Helen Pauline					2. Date of Death Month Day Year March 21 2000			3. Time of Death 7:30 AM	
	4a. Facility Name (If not institution, give street and number) Harbor Hospital Center					4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-07-1053		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 25, 1914		9. Birthplace (State or Foreign Country) MD.	
	Usual Residence of Decedent					10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					10e. Street and Number 6415 HARTWAIT ST.			10f. Zip Code 21224	
	10g. Citizen of What Country? USA					11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:					14. Race - American Indian, Black, White, etc. Specify: WHITE			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR					16b. Kind of Business/Industry LEVER BROTHERS				
	17. Father's Name (First, Middle, Last) ANDREW SOJAK					18. Mother's Name (First, Middle, Maiden Surname) FRANCES WALLA				
To Be Completed by Physician/Medical Examiner	19a. Intomment's Name/Relationship (Type, Print) JULIA MUSKA/SISTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 CHESCO AVE., BALTIMORE, MD. 21231				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) ST. STANISLAUS CEM. 3/24/2000 BALTIMORE, MD.				
	21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Edema Due to (or as a consequence of): b. Congestive heart failure Due to (or as a consequence of): c. Dilating Cardiomyopathy Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death 3 weeks 2 years 3 years				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day Year) M					
28b. Time of Injury M					28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier Hani Salama, MD					
29c. License number P12993					29d. Date signed (Month, Day, Year) March 21, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hani Salama, 3001 South Hanover Street, Baltimore, MD 21225					31. Date filed (Month, Day, Year) MAR 24 2000					
32. Registrar's Signature <i>[Signature]</i>										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09473

Amended item#5 perFHG 781 3/31/2000 EW

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Edith Marie Dodge		2. Date of Death Month March Day 22 Year 2000		3. Time of Death 9:40 PM	
4a. Facility Name (If not institution, give street and number) 916 N. Marlyn Avenue			4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore
5. Social Security Number 224 38 1932	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 9, 1934
9. Birthplace (State or Foreign Country) Virginia					
Usual Residence of Decedent					
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Essex		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 916 N. Marlyn Avenue			10f. Zip Code 21221		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress	
16b. Kind of Business/Industry Restaurant		17. Father's Name (First, Middle, Last) William Talbot		18. Mother's Name (First, Middle, Maiden Summa) Mable Casey	
19a. Informant's Name/Relationship (Type, Print) Robert R. Dodge Jr. (husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 N. Marlyn Avenue Essex, Maryland 21221		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gardens		20c. Location - City or Town, State Baltimore County, Md	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Bruzdinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Squamous Cell Carcinoma of lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D30133		29d. Date signed (Month, Day, Year) March 23, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Connelly MD 107 Beacon Road Middle River, Maryland 21220					
31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09474

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sarah Mae Daniels						2. Date of Death Month Day Year March 22, 2000		3. Time of Death 5:30am	
	4a. Facility Name (If not institution, give street and number) 5133 West Running Brook Road						4b. City, Town, or Location of Death Columbia Maryland		4c. County of Death Howard	
Funeral Director	5. Social Security Number 238-16-4990		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) May 1, 1904		9. Birthplace (State or Foreign Country) NC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Howard		10c. City, Town or Location Columbia Maryland				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 5133 West Running Brook Road				10f. Zip Code 21044		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper			16b. Kind of Business/Industry Domestic		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Unk.						18. Mother's Name (First, Middle, Maiden Surname) Unk.			
	19a. Informant's Name/Relationship (Type, Print) Marjorie Crawford / Granddaughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4320 Stevens Battle Lane Fairfax VA 22033			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Restland Park Cemetery March 27, 2000		20c. Location - City or Town, State Monroe, PA			
	21. Signature of Funeral Service Licensee Victor P. Doda, Jr.						22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230			
Physician /Medical Examiner	23a. Per11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier Steven Geller MD				29c. License number d34613		29d. Date signed (Month, Day, Year) March 22, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Geller MD 9501 Old Annapolis Rd Ellicott City MD 21042									
	31. Date filed (Month, Day, Year) MAR 24 2000				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09475

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rosa P. Dozier

2. Date of Death

Month Day Year

March 16, 2000

3. Time of Death

8:00 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-86-2849

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 4, 1966

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4905 Queensberry Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Raleigh Dozier

18. Mother's Name (First, Middle, Maiden Summa)

Rosa Fulton

19a. Informant's Name/Relationship (Type, Print)

Mrs. Rosa McNeil

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4905 Queensberry Ave. Balto. Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Data

3/25/00

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2322 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cervical Cancer

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. L. Russ

29c. License number

D43725

29d. Date signed (Month, Day, Year)

3/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MATHEMOUL 201-109 Back River Neck Road Baltimore MD 21221

State
Registrar

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

B. Spauld

Rosie Dozier
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

00 09476

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>DAISY Douglas</i>				2. Date of Death Month Day Year MARCH 20, 2000		3. Time of Death 1704 PM
	4a. Facility Name (If not Institution, give street and number) JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A
Funeral Director	5. Social Security Number <i>213-34-4106</i>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>61</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>4-16-38</i>	9. Birthplace (State or Foreign Country) <i>N.C.</i>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <i>2813 Ashland Ave</i>			10f. Zip Code <i>21205</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2nd grade</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Unit Clerk</i>			16b. Kind of Business/Industry <i>J. H. H.</i>	
	17. Father's Name (First, Middle, Last) <i>James Brown</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Victoria Thacker</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>John L. Douglas</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2813 Ashland Ave, Baltimore, MD 21205</i>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest Vet Cem</i>		20c. Location - City or Town, State <i>3-27-00 Owings Mills, MD</i>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <i>BALTIMORE, MD March F. H. East 1101 E. North Ave</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number OCME		29d. Date signed (Month, Day, Year) MARCH 21, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MD Gregory P. Worell 111 Penn Street, Baltimore, Maryland 21201</i>							
31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09477

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence L. DeVoe

2. Date of Death

Month

Day

Year

March 17, 2000

3. Time of Death

2355

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

216-12-0394

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

June 21, 1914

9. Birthplace (State or Foreign Country)

Baltimore City, MD.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1477 Charlestown Drive

10f. Zip Code

21040

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6 yrs.

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Christian W. Seitz

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Miller

19a. Informant's Name/Relationship (Type, Print)

Russell G. DeVoe (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

696 Ritchie Highway Severna Park, MD.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Spring Church Cem.

Date

3/22/2000

20c. Location - City or Town, State

Forest Hill, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

E.F. Lassahn Funeral Home

11750 Belair Road Kingsville, MD. 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRACEREBRAL HEMORRHAGE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

2005

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Forest Hill, MD

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D22543

29d. Date signed (Month, Day, Year)

March 20 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Pittelli 2005 ROCK SPRING RD Forest Hill, MD

State
Registrar

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

DeVoe, Florence

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09478

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUSSELL H DAVIS				2. Date of Death Month Day Year March 20, 2000		3. Time of Death 8:00 pm		
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 577-46-7387		6. Sex XX M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) June 29, 1934		
	9. Birthplace (State or Foreign Country) Michigan		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 611 Round Oak Road		10f. Zip Code 21204		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Data Systems Analyst		16b. Kind of Business/Industry Computer		17. Father's Name (First, Middle, Last) Jesse Edward Davis		18. Mother's Name (First, Middle, Maiden Surname) Catherine Hughes	
19a. Informant's Name/Relationship (Type, Print) Janet P. Davis		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 611 Round Oak Road Towson, Maryland 21204		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		20c. Location - City or Town, State 3/25/00 Lutherville, Maryland	
21. Signature of Funeral Service Licensee <i>Denise Stephen Kenake</i>		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Fibrillation Due to (or as a consequence of): b. Acute myocardial infarction Due to (or as a consequence of): c. A.S.C.V.D. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Paul J. Edgar, M.D.</i>		29c. License number D 01939		29d. Date signed (Month, Day, Year) 3/21/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Edgar, M.D., 515 Fairmount Avenue, Suite 310, Towson, Maryland 21204		31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1825

James O. Thompson

1825

James O. Thompson

1825

1825

1825

1825

1825

1825

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

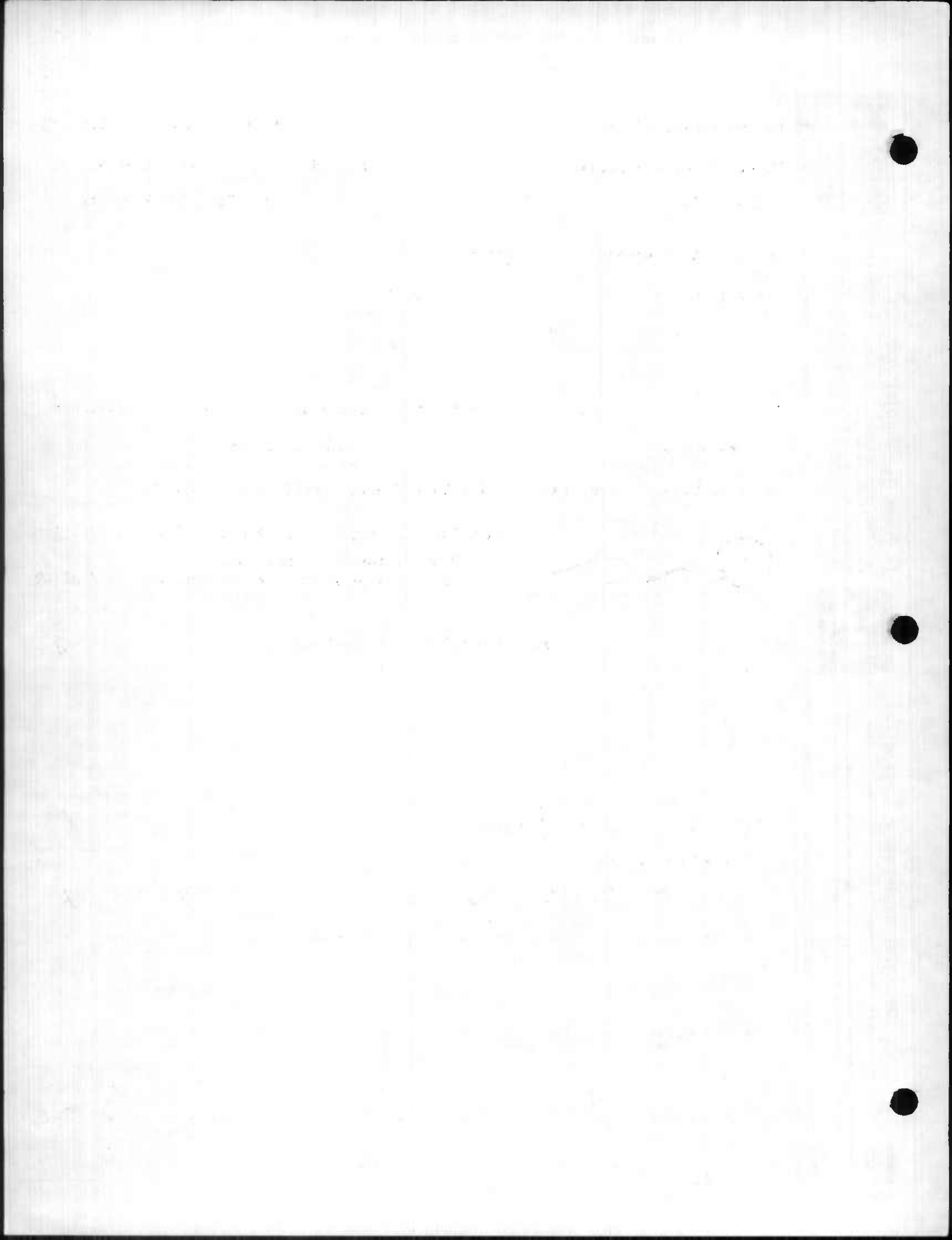
State of Maryland / Department of Health and Mental Hygiene

00 09479

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eugene Hewitt Edwards				2. Date of Death Month Day Year March 21, 2000		3. Time of Death 5:05 PM	
	4a. Facility Name (If not institution, give street and number) Future Care, Chesapeake				4b. City, Town, or Location of Death Arnold		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 212-30-1244		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 3, 1930	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: Anne Arundel 10c. City, Town or Location: Arnold 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		11. Merit Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer / Proofreader	
	16b. Kind of Business/Industry Federal Government		17. Father's Name (First, Middle, Last) George Edwards		18. Mother's Name (First, Middle, Maiden Surname) Kathryn Hewitt		19a. Informant's Name/Relationship (Type, Print) Janet F. Wilder / Daughter	
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 279 Yale Court, Arnold, Maryland 21012		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State 3/24/2000 Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death): Electrolyte Imbalance Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death days	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure Coronary artery disease Diabetes Mellitus type II				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify):	
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
State Registrar	29b. Signature and title of certifier 		29c. License number D-40521		29d. Date signed (Month, Day, Year) March 22, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ochaney	
	31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature 		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 Wilkens Avenue Suite 302 Baltimore, MD 21229			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09480

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Walter Eckstein				2. Date of Death Month Day Year March 21 2000		3. Time of Death 3:45 PM	
	4a. Facility Name (If not institution, give street and number) Glen Meadows Retirement Community				4b. City, Town, or Location of Death Glen Arm		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 027-07-5062		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 6, 1901	
	9. Birthplace (State or Foreign Country) Massachusetts		10a. State MD		10b. County Baltimore		10c. City, Town or Location Glen Arm	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 11630 Glen Arm Rd.		10f. Zip Code 21057		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Manufacturing				
17. Father's Name (First, Middle, Last) Paul Eckstein				18. Mother's Name (First, Middle, Maiden Surname) Marie Cahill				
19a. Informant's Name/Relationship (Type, Print) John Eckstein/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Highland Ridge Dr., Phoenix, MD 21131				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		20c. Location - City or Town, State Timonium, MD		20d. Date 3/25/00		
21. Signature of Funeral Service Mortician <i>Lowell M. Lammon</i>				22. Name and Address of Facility Leomon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration pneumonia Due to (or as a consequence of): b. oropharyngeal dysphagia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. chronic lung disease								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Dr. Anthony Kelly, MD</i>				29c. License number 025205		29d. Date signed (Month, Day, Year) March 22, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A.R. Ley 6301 N. Charles St - Balto, Md 21208								
31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09481

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jack William Emerson

2. Date of Death

March 19 Year 2000

3. Time of Death

5:37pm

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

320-28-9206A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 26, 1936

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2002 Paulette Rd., Apt. 2

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mig. Welding

16b. Kind of Business/Industry

Equipment Co.

17. Father's Name (First, Middle, Last)

Jack W. Emerson

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Lappi

19a. Informant's Name/Relationship (Type, Print)

Maria L. Emerson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2002 Paulette Rd., Apt. 2 Dundalk, Md. 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baltimore-Washington Crematory LAurel, Md.

3-23-2000

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton-Matthews Funeral Home, Inc.
2134 Willow Spring Rd., Balto., Md. 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. cardiac arrhythmia
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

minutes

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. ASCVD
Due to (or as a consequence of):

years

c. hypertension
Due to (or as a consequence of):

years

d. COPD
Due to (or as a consequence of):

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D25753

29d. Date signed (Month, Day, Year)

March 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. ANDREW SUMNER, MD 5601 Loch Raven Blvd, Baltimore 21239

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09482

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles William Freeland, Sr.				2. Date of Death Month Day Year MARCH 23, 2000		3. Time of Death 10:55 AM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-09-2092		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Dec 11, 1918	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Cockeysville	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Vending Machines		17. Father's Name (First, Middle, Last) Elmer Emory Freeland		
18. Mother's Name (First, Middle, Maiden Surname) Ada Elizabeth Bell		19a. Informant's Name/Relationship (Type, Print) Joan Lee Wernz/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10917 Gateview Road, Cockeysville, MD 21030		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns.		20c. Date 3/25/00		20d. Location - City or Town, State Timonium, Maryland		21. Signature of Funeral Service Licensee Bryan W. Clary		
22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CONGESTIVE HEART FAILURE Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): GASTRO INTESTINAL BLEEDING Due to (or as a consequence of): EMPHYEMA OF THE LEFT LUNG		23b. Approximate Interval Between Onset and Death ONE WEEK YEARS ONE WEEK MONTH		23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS		
23d. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes 2 No		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Natividad D. de Leon, M.D.		29c. License number D19505		29d. Date signed (Month, Day, Year) 3/24/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIVIDAD D. DELEON, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND		31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature [Signature]		33. Registrar's Title [Signature]		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09483

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Frederick Flater, Jr.				2. Date of Death Month Day Year MARCH 21, 2000		3. Time of Death 1842	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL 900 CATON AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 220-30-5775	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 4, 1935		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3439 Liberty Gardens Road				10f. Zip Code 21244		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Estimator		16b. Kind of Business/Industry Sheet Metal Company		
17. Father's Name (First, Middle, Last) George F. Flater, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Hazel Sarah Warner				
19a. Informant's Name/Relationship (Type, Print) Carol McDermott (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Newfield Road, Gwynn Oak, MD 21207				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State 3/24/00 Sykesville, MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228				
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Minutes
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcohol Abuse						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Attending Physician				29c. License number D51853		29d. Date signed (Month, Day, Year) March 21, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Silverman, MD 900 Caton Avenue Baltimore 21229								
31. Date filed (Month, Day, Year) MAR 24 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020
Permits: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Flater, George
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09484

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alvin Lee Faul

2. Date of Death

March 20 2000

3. Time of Death

10:59AM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

438-54-7917

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 1, 1939

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Brandywine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10505 Cedarville Road Lot 922

10f. Zip Code

20613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic Heating & Air

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

John Baptist Faul

18. Mother's Name (First, Middle, Maiden Surname)

Eula LeBeouf

19a. Informant's Name/Relationship (Type, Print)

Jean C. Faul (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10505 Cedarville Road Lot #922, Brandywine

March 24 2000

MD 20613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

▶ *St. E. St.*

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old

Alexandria Ferry Road, Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Myocardial Infarction*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Previous Myocardial Infarction*

Due to (or as a consequence of):

c. *Hypertension*

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Anxiety

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *St. E. St.*

29c. License number

D 23826

29d. Date signed (Month, Day, Year)

3/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glenn R. Edgecombe M.D. 7700 Old Branch Ave. Clinton, Md 20735

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

*Benjamin S. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 3065.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09485

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY G. FOERTSCHBECK				2. Date of Death Month Day Year MARCH 13, 2000				3. Time of Death 6:25 PM			
	4a. Facility Name (If not institution, give street and number) JOSEPH RICHEY HOUSE 828 N. EUTAW ST.				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A			
Funeral Director	5. Social Security Number 216-12-2368		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 9/27/1919		9. Birthplace (State or Foreign Country) MD.			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 909 S. CONKLING ST.				10f. Zip Code 21224		10g. Citizen of What Country? USA					
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PAPER SLITTER				16b. Kind of Business/Industry CROWN CORK & SEAL					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JOHN H. FOERTSCHBECK				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE ROCKSTROH							
	19a. Informant's Name/Relationship (Type, Print) MARIE FOERTSCHBECK/SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 S. CONKLING ST., BALTIMORE, MD. 21224							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SACRED HEART OF JESUS		Date 3/17/00		20c. Location - City or Town, State BALTIMORE, MD.					
	21. Signature of Funeral Service Licensee <i>[Signature]</i> MO0521				22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hyperkalemia CHF Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 6 yrs 6 yrs	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number JO8900		29d. Date signed (Month, Day, Year) 3-21-00					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert C. Iwaniuk 828 N. Eutaw St. Baltimore, Md 21201											
1414	31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature <i>[Signature]</i>									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09486

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Gearon

2. Date of Death

Month 3 Day 23 Year 00

3. Time of Death AM

11:03

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel, MD

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

091-03-7234

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 30, 1904

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15741 Millbrook Lane

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Cruise Ship

17. Father's Name (First, Middle, Last)

Daniel F. Gearon

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Sheehan

19a. Informant's Name/Relationship (Type, Print)

Raymond D. Gearon/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111-20 73rd Avenue Forest Hills, New York 11375

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Calvary Cemetery

Date

03/27/00

20c. Location - City or Town, State

Woodside, New York

21. Signature of Funeral Director

22. Name and Address of Facility

Fleck Funeral Home, Inc.
7601 Sandy Spring Road Laurel, Maryland 2070723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 week

b. Aortic Stenosis

Due to (or as a consequence of):

3 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

29c. License number

D47062

29d. Date signed (Month, Day, Year)

3/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ann Hagen 14201 Laurel Park Dr. Ste 214 Laurel, MD 20707

State
Registrar

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09487

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ATIN GUHA		2. Date of Death Month Day Year MARCH 17, 2000		3. Time of Death 3:09pm
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Funeral Director	5. Social Security Number 043-42-4065	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	8. Date of Birth (Month, Day, Year) January 1, 1938	9. Birthplace (State or Foreign Country) Bangladesh
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Gambrills		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 2026 Hermitage Hills Drive		10f. Zip Code 21054		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Asian Indian		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physician		16b. Kind of Business/Industry Health		
	17. Father's Name (First, Middle, Last) Narendra Guha		18. Mother's Name (First, Middle, Maiden Surname) Usha		
	19a. Informant's Name/Relationship (Type, Print) Pamela Guha Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2026 Hermitage Hills Drive Gambrills, Maryland 21054		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Crem.		20c. Location - City or Town, State Laurel, Maryland
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. IDIOPATHIC PULMONARY FIBROSIS				
	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. TWO MONTHS				
	Due to (or as a consequence of): Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier WILLIAM W. LECATES HOUSE OFFICER					
29c. License number RES-000					
29d. Date signed (Month, Day, Year) MARCH 17, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM W. LECATES, M.D., JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND 21287					
31. Date filed (Month, Day, Year) MAR 24 2000					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09488

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eileen Gosnell

2. Date of Death

Month Day Year
March 22 2000

3. Time of Death

1:15 pm

4e. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-28-4780

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Feb 26 1925

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1930 Main Avenue

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Household

17. Father's Name (First, Middle, Last)

Ernest Windle

18. Mother's Name (First, Middle, Maiden Surname)

Mary Carr

19e. Informant's Name/Relationship (Type, Print)

Donna Clark (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7542 Rock Creek Way, Pasadena, MD. 21122

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

March

20c. Location - City or Town, State

23,2000 Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stallings Funeral Home, P.A.
3111 Mountain Rd., Pasadena, MD. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D51051

29d. Date signed (Month, Day, Year)

March 22, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Andres Salazar 711 Maidenchoice Lane, Catonsville, MD, 21228

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

12.5.04

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09489

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Oscar A. Gaimaro						2. Date of Death Month Day Year March 19, 2000		3. Time of Death 1437 pm						
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A						
Funeral Director	5. Social Security Number 212.48.9086		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) 12.20.1925		9. Birthplace (State or Foreign Country) Argentina						
	Usual Residence of Decedent														
10a. State MD		10b. County Baltimore		10c. City, Town or Location Landsdowne				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 3160 Ryerson Circle.						10f. Zip Code 21227		10g. Citizen of What Country? USA							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed				16b. Kind of Business/Industry Rental							
17. Father's Name (First, Middle, Last) Michael Gaimaro						18. Mother's Name (First, Middle, Maiden Surname) Margarita Caruso									
19a. Informant's Name/Relationship (Type, Print) Lidia Gaimaro - Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3160 Ryerson Circle. Baltimore, MD 21227									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		20c. Location - City or Town, State 3/24/2000 Elkridge, MD									
21. Signature of Funeral Service Licensee M. K. Marshall						22. Name and Address of Facility Gary L. Kaufman Fun'l Home @ Meadowridge Mem. Park 7250 Washington Blvd. Elkridge, MD 21075									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 20, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) MAR 24 2000				32. Registrar's Signature [Signature]											

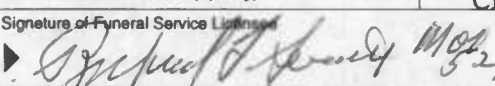
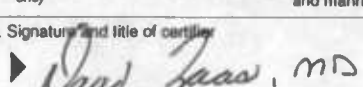
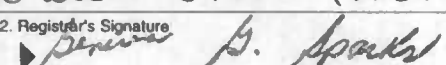
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09490

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ADDIE GOWER				2. Date of Death Month Day Year MARCH 19, 2000		3. Time of Death 9:15	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-18-3471		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 16, 1924	
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 7028 EASTERN AVE.		10f. Zip Code 21224		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry own home			
	17. Father's Name (First, Middle, Last) WILLIAM JOHNSON				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE NEILS			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) BERNARD GOWER/HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7028 EASTERN AVE. BALTIMORE, MD. 21224			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE WASHINGTON CREMATORY		20c. Location - City or Town, State 3/22/00 LAUREL, MD.		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. EMPHYSEMA				Approximate Interval Between Onset and Death 30 YEARS			
	Due to (or as a consequence of): b. CORONARY ARTERY DISEASE				10 YEARS			
To Be Completed by Physician/Medical Examiner	Due to (or as a consequence of): c.							
	Due to (or as a consequence of): d.							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier  MD				29c. License number RES-000		29d. Date signed (Month, Day, Year) MARCH 19, 2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID ZAAS, MD, 600 WOLFE STREET, BALTIMORE, MARYLAND 21287							
	31. Date filed (Month, Day, Year) MAR 24 2000				32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09491

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT A. HEINLEIN						2. Date of Death Month Day Year March 21 2000			3. Time of Death 1633	
	4a. Facility Name (If not institution, give street and number) Fallston General Hospital						4b. City, Town, or Location of Death Fallston			4c. County of Death Harford	
Funeral Director	5. Social Security Number 216-03-0301		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 16, 1917		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10c. City, Town or Location Forest Hill				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 109 F. Sunshine Court				10f. Zip Code 21050		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Planner				16b. Kind of Business/Industry Electronics Co.				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Anthony Joseph Heinlein						18. Mother's Name (First, Middle, Maiden Surname) Helen Beatrice Erdman				
	19a. Informant's Name/Relationship (Type, Print) Anna R. Heinlein (Wife)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 F. Sunshine Court, Forest Hill, MD 21050				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Date 3/24/00		20d. Location - City or Town, State Baltimore, Maryland				
	21. Signature of Funeral Service Licensee Brian A. Willner						22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Respiratory Failure Due to (or as a consequence of): b. Acute Interstitial Pneumonia Due to (or as a consequence of): (Harrison-Rich Syndrome) c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 2 weeks 2 weeks				
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic atrial Fibrillation						23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
State Registrar	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Albert S.C. Sun, M.D.		29c. License number D18779		29d. Date signed (Month, Day, Year) March 21, 2000				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Albert S.C. Sun, MD, 1716 Harford Road #105 Fallston MD 21047										
	31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature B. Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09492

AMEND#26 VRBL RSPNSE. D. BOSTON G781 3-24-2000 JAB

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lida J. Hoehn

2. Date of Death

03

Day

11

Year

00

3. Time of Death

0645

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-12-8618

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

05/16/1912

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4724 Shamrock Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
9th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Clothing Company

17. Father's Name (First, Middle, Last)

James Butler

18. Mother's Name (First, Middle, Maiden Surname)

Mary A. Burnatt

19a. Informant's Name/Relationship (Type, Print)

Mary R. Taylor (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

510 Tolna Street, Baltimore, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem.

Date

3/14/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Brian A. Wilkins

22. Name and Address of Facility

Schumnek Funeral Home, Inc.

3331 Brehms Lane, Baltimore, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Right upper Lobe Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease Exacerbation

Paroxysmal Atrial Fibrillation

Microvascular Disease leading to Bilateral Lower Extremity Ischemia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sheila Gonzalgo, MD

29c. License number

KES 000

29d. Date signed (Month, Day, Year)

03/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Bayview Medical Center 4940 Eastern Ave, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

مجلس الشورى



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09493

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Andra-Lee Hanscom				2. Date of Death Month Day Year March 22, 2000		3. Time of Death 3:45PM														
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A														
Funeral Director	5. Social Security Number 006-82-1869		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) AUG 26, 1959														
	Usual Residence of Decedent		10a. State Maine		10b. County York		10c. City, Town or Location Kennebunk														
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 50 Heath Road		10f. Zip Code 04043		10g. Citizen of What Country? Canada														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mortgage Processor		16b. Kind of Business/Industry Bank																
	17. Father's Name (First, Middle, Last) William Gordon Black				18. Mother's Name (First, Middle, Maiden Surname) Jeannine Coderre																
	19a. Informant's Name/Relationship (Type, Print) William Hanscom/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 Heath Road Kennebunk, Maine 04043																
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 3/24/00		20c. Location - City or Town, State Baltimore, MD														
	21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Pulmonary Embolus</td> <td>Approximate Interval Between Onset and Death 4 days</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Pulmonary Embolus	Approximate Interval Between Onset and Death 4 days	b.	Due to (or as a consequence of):		c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Pulmonary Embolus	Approximate Interval Between Onset and Death 4 days																	
b.		Due to (or as a consequence of):																			
c.		Due to (or as a consequence of):																			
d.		Due to (or as a consequence of):																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paraparesis Rheumatoid Arthritis																					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier Mark W. Manoso, MD				29c. License number RES-000		29d. Date signed (Month, Day, Year) March 22 2000															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark W. Manoso 600 North Wdf St Baltimore MD 21287																					
31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature Barbara B. Smith																			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09494

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA CLAIRE HEWITT

2. Date of Death

Month Day Year
MARCH 22, 2000

3. Time of Death

20:21

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

235-48-2655

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 31, 1933

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1033 Spangler Way

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Packer Inspector

16b. Kind of Business/Industry

Plastic Mfg. Company

17. Father's Name (First, Middle, Last)

Charles H. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Edna B. Goff

19a. Informant's Name/Relationship (Type, Print)

Brenda D. Prince (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

710 Gregwood Copurt Baltimore, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens

Date

3/25/00

20c. Location - City or Town, State

Baltimore County, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdziński Funeral Home PA

1407 Old Eastern Ave Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypercarbic respiratory failure
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wen-Hsiang Lee, M.D.

29c. License number

Bayview# P20308

29d. Date signed (Month, Day, Year)

March 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wen-Hsiang Lee 4940 Eastern Ave., Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09495

AMEND ITEM: #23 10A-FILPER F.H. G781 3-24-2000 WR.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RANDOLPH T. HALL, JR.

2. Date of Death

Month
March

Day

2, 2000

3. Time of Death

1015 A.M.

4a. Facility Name (If not Institution, give street and number)

6418 4th Avenue

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-58-9686

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

5/11/46

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

FAYETTEVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2529 VESTAL AVE.

6418 4th Avenue

10f. Zip Code

28301

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: '78-'92

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 Yrs.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Retired/U.S. Army

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Randolph T. Hall, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Davis

19a. Informant's Name/Relationship (Type, Print)

Angela D. Hall/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9901 Greenbelt Rd. # 102, Lanham, Md. 20706

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory, Inc. 3/8/00

Data

20c. Location - City or Town, State

Beltsville, Md.

21. Signature of Funeral Service Licensee

James H. Pratt

22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.

4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma Prostate

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DMF

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) SISTER RESIDENCE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James H. Pratt MD DMF

29c. License number

D00428

29d. Date signed (Month, Day, Year)

MAR 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRA N. BRECHER, MD 2101 Medical Park Dr., # 304, Silver Spring, Md. 20902

31. Date filed (Month, Day, Year)

MAR 06 2000

32. Registrar's Signature

James H. Pratt

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

MAR 6 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09496

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Robert Hughes				2. Date of Death Month Day Year March 20, 2000				3. Time of Death 17 42		
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 578 36 8828		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Jan 10, 1913		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent										
10a. State MD		10b. County P.G.		10c. City, Town or Location Temple Hills				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 5910 Center Drive				10f. Zip Code 20748		10g. Citizen of What Country? United States					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tariff Examiner Retired				16b. Kind of Business/Industry Federal Government			
17. Father's Name (First, Middle, Last) Charles Joseph Hughes					18. Mother's Name (First, Middle, Maiden Surname) Katherine Gray						
19a. Informant's Name/Relationship (Type, Print) Irene Hughes (WIFE)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5910 Center Drive, Temple Hills, Maryland 20748						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery March 25, 2000 Suitland, Maryland			20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee J. S. Sitt					22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertension Due to (or as a consequence of): b. Ventricular Fibrillation Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Chronic Myelogenous Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Steven R. Lilla, Ph.D., M.D.			29c. License number H36078		29d. Date signed (Month, Day, Year) 3-20-99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN R. LILLA 7600 CANNON AVE., TAKOMA PARK, MD 20912											
31. Date filed (Month, Day, Year) MAR 24 2000			32. Registrar's Signature Benjamin B. Sparks								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 09497

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elmer Lee Hedrick				2. Date of Death Month March Day 20 Year 2000		3. Time of Death 1633	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 232-36-9181		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 27, 1925	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Gambrills	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2134 Old Dairy Farm Road		10f. Zip Code 21054		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Plastics Plant			
	17. Father's Name (First, Middle, Last) Shafter Lee Hedrick				18. Mother's Name (First, Middle, Maiden Surname) Mamie Flanagan			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Bonnie Hedrick (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2134 Old Dairy Farm Road, Gambrills, MD 21054			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery		20c. Location - City or Town, State Glen Burnie, MD		20d. Date 03/23/2000	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Thomas A. Hardesty				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic shock Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Lymphoma Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death a. 1 day b. 3 days c. 2 months d. 			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acute and chronic renal failure						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Berry on O				29c. License number 00029571		29d. Date signed (Month, Day, Year) 3/21/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Berry MD 1655 Crofton Blvd suite 101 Crofton MD 21114							
State Registrar	31. Date filed (Month, Day, Year) MAR 24 2000				32. Registrar's Signature James B. Sparks			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09498

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eric Edmund Hattendorf

2. Date of Death
Month Day Year

March 22, 2000

3. Time of Death

5:15 a.m.

4a. Facility Name (If not institution, give street and number)

Augsburg Lutheran Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore Co.

Funeral
Director

5. Social Security Number

099-19-189

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 29, 1908

9. Birthplace (State or Foreign Country)

Wilhelmsau, Germany

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6811 Campfield Road

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Instrument Tech.

16b. Kind of Business/Industry

Reeves Instrument

17. Father's Name (First, Middle, Last)

August Hattendorf

18. Mother's Name (First, Middle, Maiden Summa)

Marie Hsen

19a. Informant's Name/Relationship (Type, Print)

Erich R. Hattendorf - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

327 Norgulf Road Reisterstown, Maryland 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Pk. March 25, 2000 Timonium, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd. Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Parkinson's disease

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37573

29d. Date signed (Month, Day, Year)

March 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jrf Zibell MD 7220 Park Heights Ave Baltimore MD 21202

31. Date filed (Month, Day, Year)

MAR 2 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

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1942-1943

1942-1943

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09499

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLORIA HILTON		2. Date of Death Month Day Year MARCH 22, 2000		3. Time of Death 0049
	4a. Facility Name (If not institution, give street and number) 490 MAINVIEW COURT		4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 218-36-0743	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	8. Date of Birth (Month, Day, Year) APR. 23, 1940	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County ANNE ARUNDEL	10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 490 MAINVIEW COURT		10f. Zip Code 21061		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATIVE CLERK
	17. Father's Name (First, Middle, Last) HENRY BERNHARDT		18. Mother's Name (First, Middle, Maiden Surname) JEAN DICKOV		19. Informant's Name/Relationship (Type, Print) BRUCE HILTON / HUSBAND
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO		20c. Location - City or Town, State 3/23/00 BALTIMORE, MD
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): b. Arteriosclerotic Heart Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier [Signature] Deputy		29c. License number D06054		29d. Date signed (Month, Day, Year) 3/23/00
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Sparks, MD 645 America 21035				
	31. Date filed (Month, Day, Year) MAR 24 2000		32. Registrar's Signature [Signature]		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 09500

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert L. Jones

2. Date of Death

Mar. 21, 2000

3. Time of Death

5:40pm

4a. Facility Name (If not institution, give street and number)

Genesis Elder Care Ctn. Hamilton

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

250-42-8381

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02-14-30

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10e. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3419 Lyndale Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Construction

16b. Kind of Business/Industry

Construction Co.

17. Father's Name (First, Middle, Last)

Jeff Jones

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Woodard

19e. Informant's Name/Relationship (Type, Print)

Rose Ashford

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

#419 Lyndale Avenue Baltimore, Maryland

21213

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenmount Cemetery 03-25-2000 Baltimore, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202
March F.H. East 1101 E. North Ave.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Stroke
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

6 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 8 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45475

29d. Date signed (Month, Day, Year)

3/22/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M. Rahmams 17 Antone Lane #105 Balt. MD 21227

State
Registrar

31. Date filed (Month, Day, Year)

MAR 24 2000

32. Registrar's Signature

Benjamin S. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

